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ABSTRACT

This study examines culture and illness among Latino immigrants living in Washington, D.C. Both newcomers and established residents with Latin American origins are included in three levels of inquiry: (1) a study of beliefs and perceptions about disease and the practices followed in the management of illness; (2) the identification of levels of stress by socio-cultural characteristics; and (3) the examination of patterns of conflict resolution. A main theme of the research is the pattern of adaptation shown by these immigrants as they enter the United States and begin to experience problems in communication, poverty, and work in the urban context. These stress-provoking problems lead to adaptive strategies which are interwoven with concepts and meanings from many ideologies. Latino responses to stress and to American health services give insight into the changing values of immigrants and the kinds of questions with which health personnel must deal in their roles as agents of these changes. Data are presented in nine chapters as follows: (1) How It Happened: Perspectives of the Anthropologist; (2) Latin American Popular Medicine and the Study of Stress; (3) Entry and Settlement of the Immigrants; (4) Patterns of Work; (5) Symptoms of Illness and Cross-Cultural Communication; (6) Syndromes of Illness and Popular Medicine; (7) The Health Opinion Survey and Measurement of Stress; (8) "Controlarse" and the Problems of Life; and (9) Latin American Immigrants Transform Society. Three appendices include letters, permission activities necessary for the research process, and surveys used in the study. The book concludes with a 135-item bibliography and a publications list of the Research Institute on Immigration and Ethnic Studies (RIIES). (VM)

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Culture, Disease, and Stress among Latino Immigrants

Lucy M. Cohen

The Catholic University of America

Washington, D.C.

RIIES Special Study
Research Institute on Immigration and Ethnic Studies
Smithsonian Institution, Washington, D.C., 1979

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The Research Institute on Immigration and Ethnic Studies, founded in 1973, is a part of the Smithsonian's Center for the Study of Man. The Research Institute focuses on immigration flows which have been affected by legislation since 1965. It also explicitly includes American extraterritorial jurisdictions among its scholarly concerns.

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To Isabel Sirias Garrovillas
lifelong model, friend, and immigrant

I think it can be said that there has never yet been a definition of what is maximum medical care, and this is now in the papers daily. Medical care is a right and not a privilege, but how much medical care?

It is stated that since it is going to be a right there will be a bottom level, a minimum; the maximum cannot be decided. The president of the United States has a personal physician available twenty-four hours a day. On the other end of the scale, a man or a woman may be going around half dead on his feet, and won't have a doctor at all.

(Dorothy Gill, M.D., comments from transcript, Greater Washington Health Conference for the Spanish Speaking People, December 11, 1971.)

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FOREWORD

The Research Institute on Immigration and Ethnic Studies was established in 1973 as part of the Smithsonian Institution. Its objectives are to stimulate, facilitate, and disseminate research on immigration into the United States and its overseas jurisdictions. The Institute has special interest in new immigrants who have entered the country since the Immigration Act of 1965 because this legislation has contributed to the emergence of a dramatic new chapter in the history of immigration in the United States.

The Research Institute views international immigration as a multifaceted process with implications for research and policy. A sizeable proportion of new immigrants come from areas which in the past have not been major sources of U.S. immigration. Many emigrate from newly-independent or developing nations. Those who have entered from neighboring areas such as Latin America present new demographic and sociocultural characteristics which have been largely overlooked. These newcomers pose challenges for students of immigration and ethnicity, and for policymakers. We believe that the new immigration is not only a social and historical phenomenon; it is a public issue as well. Consequently, in many of its own past programs and publications, RIIES has drawn attention to both the national and international implications of the new immigration. The present book focuses on a complementary aspect of the lives of immigrants -- on their settlement in a specific urban metropolitan area which is the typical site of residence of immigrants in this country. The volume deals with patterns of adaptation of people of Latin American heritage after entry (legal or illegal) and with institutions of service to the immigrants themselves, on the local and neighborhood levels. These are some levels of concerns and experiences that tend to be overlooked by public institutions and the active anti-immigration and anti-immigrant establishment as they operate, not only in Washington, D.C. but throughout the nation.

The Research Institute on Immigration and Ethnic Studies is proud to present *Culture, Disease, and Stress Among Latinos* as the first publication in our monograph series. It is the result of independent study carried out by one of our first post-doctoral fellows during her year of sabbatical leave from The Catholic University of America. *Culture, Disease, and Stress Among Latinos* is an ethnographic study about the lifeways of new Latin American immigrants in Washington, D.C. The nation's capital is the scene of scandalous raids in search of "illegal aliens" among Latin American populations, by officers of the Immigration and Naturalization Service. It is a metropolis known most for its pervasive low political and high diplomatic culture but it has received limited recognition for its growing cosmopolitan orientation on the local and folk levels which has resulted from the influx and activities of immigrant and native minorities.

Washington, D.C. is a city of a most sophisticated but still politically disenfranchised population in the country where national and international policies take precedence over local or urban policy. *Culture, Disease, and Stress Among Latinos* addresses itself to problems of adaptation, stress and illness, as well as the problems of cross cultural communication, poverty and work in an urban metropolitan context. It is also a study of a city which should be viewed as a reflection on urban North America, insofar as it reveals institutional and cultural adversities which face new Latin residents in this country.

Dr. Lucy M. Cohen is to be congratulated for her pioneer work, one which in another sense is part of an established tradition of ethnographic studies on the urban ethnic poor of which Washington, D.C. has had well-known examples. The work reveals a serious effort on her part to be scientific and humane. It represents a high degree of convergence of anthropological and social work training, university teaching and mental health research and practice, and the sensibilities and advocacy of a woman of Latin American identity. As such, *Culture, Disease,* *and Stress Among Latinos* is an impressive challenge to the negative stereotypes which the North American public has learned to use in characterizations of the work and time ethics, family organization, and particularly, the traditional role domains of women in Hispanic cultures. Dr. Cohen leaves us with the need to rethink not only the original validity of these stereotypes but also the implications of the charges represented in her findings for the Latin American immigrants and the larger society.

We believe that the transformation of American urban cultures will be increasingly shaped by new immigrants. Policy makers in government and in the private sectors, representatives of the professions and specialists in Latin American studies, the public-at-large and the immigrants themselves, all need to give serious attention to the new populations who have challenged deeply-held beliefs and values about the lives and impact of those newly-arrived in our midst.

Therefore, we at RIIES hope our readers find *Culture, Disease, and Stress Among Latinos* not only informative but useful. We thank all those who contributed to the successful completion of this our first monograph.

Roy Simón Bryce-Laporte

General Editor and Director

Research Institute on Immigration and Ethnic Studies

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The research on which *Culture, Disease, and Stress Among Latinos* is based was funded by grant number 21725 from the National Institute of Mental Health, Center for the Study of Minority Mental Health Programs. A Biomedical Sciences Grant from the Catholic University Faculty Research Fund supported part of the preliminary pilot project and the final stages of data analysis.

The immigrants who participated in this study must remain anonymous. I am deeply grateful for their collaboration and for their hospitality.

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Jane Nakayama Cole was responsible for invaluable

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Mrs. Beverly McNamara efficiently typed several versions of the manuscript. Linnea Back conducted detailed data studies and manuscript proofreading, while Karen Kerkering assisted with special analyses.

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INTRODUCTION

This is a book about culture and illness among immigrants of Latin American origin who live in Washington, D.C. It describes concepts of disease and evidences of stress in men and women who sought treatment for their own health problems or those of members of their families. It also discusses people who at the time of the study stated that they did not have health problems, for much can be learned about the physical and emotional health of members of cultural groups by studying not only those who report illnesses but also those who consider themselves to be "well." The work focuses mainly on the lives of women because they constitute an increasingly active force in the immigration from Latin America to the United States.

The study of the lifeways of immigrants to the urban centers of the United States has been a theme of central interest to social and behavioral scientists. For immigrants are American history, as Oscar Handlin noted in his classic work, *The Uprooted*. To discover how Latin American immigrants think and feel, and how they act upon problems of disease and the stresses of life, is thus to dwell upon a familiar theme of the American experience.[1]

But there is growing recognition that the period since World War II has brought new immigrants to this country who do not fit the "ideal type" of peasant and immigrant depicted in major works about the settlement and adjustment of earlier newcomers. Passage of the landmark Immigration and Nationality Act of 1965 (PL 89-236, 79 Stat. 920.) reminds us that Americans have now chosen a policy which gives priority to *what immigrants do* rather than to *who they are*. Skill and occupation, rather than race and ethnic origin, are now the major criteria for admission to the country. However, for some regions of the world, such as Latin America, this policy obscures the realities of what it means to enter the United States, as shown by findings in the present research.

Whereas the typical pioneers of immigration in the past have been men, among Central and South Americans today it is women who occupy a central place as leaders, initiating a process which subsequently draws other family members and friends to Washington. Moreover, these women are not widows or young single persons who venture on long voyages to the promised land. Rather, they are mostly women who had established households in their places of origin and then left children behind under the care of maternal grandmothers or other kin. The availability of relatives for child care has made it possible for these women to engage in pioneering roles as migrants.

Most of the men and women entered the United States to improve their living conditions and their economic status. Some were also motivated by a desire to join relatives and friends or they had a commitment to work with a preselected employer. For all newcomers, jobs established the first line of contact with the host society. Both the women and the men worked full time (some "moonlighted" as well) in a broad range of semi-skilled and unskilled positions. Partly because Latin American women tend to have a meager formal education they have fewer options for occupational mobility than do their male compatriots, who are commonly better educated.

When the immigrants in this study first entered the United States the airports of Miami and Washington or the U.S.-Mexican border were their first glimpses of the new land. Airplanes link every Latin American nation with the Miami airport; buses and cars facilitate arrival at border points for those who have chosen to enter the country as illegal aliens. Regardless of how they come, however, the airplane remains a symbol of rapid communication for it enables good and bad news, as well as people, to travel back and forth. These immigrants are therefore not so isolated from their places of origin as were those who came in the days of sail and steam.

Anthropologists who have conducted pioneering investigations in Central and South America have devoted limited attention to the transnational migrations of these peoples or to an understanding of their lives in such U.S. cities as San Francisco, Washington, New York, Miami, and New Orleans. Yet these immigrants of the 1960s and 1970s are active creators of the present-day development of the Americas. Contemporary Latino immigrants come from complex Third World societies which are in the midst of change and revolution to settle in American cities such as Washington where the unplanned crises of urban living threaten the stability of even long-established residents. Latinos and Latinas bring the optimism of newly arrived settlers who are highly motivated by the wish to improve the status of the family group. Yet they also carry a sense of realism about the active struggles in which they have to become involved in order to achieve a sense of mastery over difficult life situations and social conditions in this country.

Theoretical issues and practical concerns have led students of immigration to consider processes of settlement and adjustment of newcomers. Anthropologists have focused much of their research in this area on the study of continuity or discontinuity of cultural traditions and the impact of new experiences. But the cultural beliefs and practices of these newcomers can no longer be single-typed as "indigenous," *mestizo*, "rural," or "urban," as they have been described frequently in literature on Latin America. Their cultural world contains interwoven segments of knowledge and meaning drawn from the many ideologies and traditions which are impinging upon Latin America.

This mosaic of tradition is manifest in the multicultural character of present-day Latino beliefs and practices about health and disease which are a principal subject of this study. The Indian heritage, the Spanish tradition, patent remedies, homeopathic therapy, and scientific biomedical tradition are all part of the cultural background which influences the Latin American immigrants as they strive to understand the etiology of a specific illness and to cope with its problems. As they face episodes of illness in Washington, Latinos absorb new beliefs and restyle the old. This is not always a simple or satisfactory process.

This research presents findings which highlight cultural influences on common Latino concepts of health and illness. The book emphasizes, in particular, links between the management of health problems in the household and processes of consultation with caregivers from the scientific biomedical community. It identifies the major sociocultural factors associated with differences in levels of stress.

The concepts of health and disease held by newcomers of Latin American origin have important mental health implications. As these immigrants deal with the specifics of each encounter with illness, they emphasize the central role of "physical" health for the attainment of their goals. Concepts of etiology used to interpret symptoms of behavioral impairment are frequently linked to organic disturbance. For example, Latinos view symptoms of stress such as depression and anger as results of bodily dysfunction. Latino parents who receive reports of a child's misbehavior in school frequently search for ways of strengthening the child's blood and bodily systems, since such measures are believed to prevent behavioral disturbances. To the Latino, the concept of mental health embodies the balance of body, mind, and spirit.

The annals of U.S. immigrant history and culture contain relatively few known records about the experiences of newcomers as they have dealt with the American systems of medical care. Examination of how new immigrants manage and cope with illness in our present-day society can offer valuable perspectives on our own care-giving institutions as well as on their ways of life. This emphasis is important. In his recent work, *Who Shall Live?* Victor Fuchs has rather dramatically drawn our attention to the problem of critical individual and societal choices which must be resolved to assist our nation in meeting the urgent crises of medical care.[2] The present work illustrates the efforts of an anthropologist to record the voices of Latino immigrants who, in dealing with the health problems of their daily lives, also offer penetrating insights into culture, disease and stress in our own society.

This volume is directed to the attention of a varied and wide-ranging readership. One obvious group, of course, consists of those who want to obtain information about the life styles and mental health problems of relatively unknown but rapidly growing groups of Spanish-speaking newcomers. By and large, mental health research on U.S.-Hispanic populations has focused on Mexican Americans with more limited attention directed towards Puerto Ricans and Cubans. The least is known about the Spanish-speaking people from Central and South America who constitute about 20 percent of the people of Hispanic heritage in the United States.

This volume reports on a group of newcomers and a group of established residents from selected Central and South American countries. There are increasing numbers of immigrants from these nations in the United States. Some have become U.S. citizens; others are permanent residents who aspire to citizenship; still others are undocumented persons known to us as "illegal aliens."

The latter are of special concern just now. The Domestic Council Committee on Illegal Aliens has pointed to economic and social issues that intensify the pressure to emigrate from some of these countries. Hence there are backlogs of applications for immigrant visas into the U.S. that contribute to the stream of illegal immigration. Those pressures and backlogs are not likely to decrease in the immediate future.

Readers concerned with understanding the impact of immigration on Latinos, and on ourselves as well, should also find this volume of interest. In recent years various official inquiries into the entry of immigrants and undocumented workers have centered on the effect on the U. S. labor market "with special concern," as the Domestic Council Committee puts it, "that the employment of the alien will not adversely affect wages and working conditions of similarly employed U.S. workers." But, "the great majority of post-1965 immigrants have entered the U.S. on the basis of family ties to U.S. residents."[3] It would seem logical, therefore, for policy-makers to give attention to the impact of immigration on these families. The findings in this book offer data which contribute to understanding why Latinos enter, how they organize their families and households, and what their working aspirations are. It offers social and cultural perspectives about stress-conducive situations and the ways in which Latinos cope with these challenges.

Finally, the book should give readers insight into the changing values of people of Hispanic heritage. The immigrants in this study do not fit the stereotype of the "mañana-directed" or "present-oriented" types described in popular works on Latin American life both in this country and in their places of origin. The participants in this study are careful planners, vigorously involved in future-oriented activity for themselves and their families. It is to be hoped, therefore, that the research findings should contribute to more dynamic perspectives about culture, mental health, and social change in the lives of Latinos who are transforming themselves as they carve new lives in our society.

CHAPTER 1

HOW IT HAPPENED: PERSPECTIVES OF THE ANTHROPOLOGIST

Anthropological inquiry still carries the connotation of research in far-off places and in someone else's culture. The present investigation was, however, undertaken in the city where I have lived for the past twenty years and among a population whose cultural heritage I share. My general research concerns in the present study grew out of longstanding theoretical interests which I have pursued in related investigations. As an anthropologist, I have studied and observed at first hand the ways in which similarities and differences in cultural beliefs, values, and practices influence the prevention and management of disease. As a social worker, I have practiced in Washington and in Latin America, with special interest in the development of effective social policy and patterns of practice, particularly in the field of health and in social action. In the present research, as in past investigations, I have endeavored to gain insight into the questions which face client populations as well as those with which agents of change must deal as they attempt to prevent problems and cope with needs. In my opinion some of the critical issues, which should be the subject of research by the applied anthropologist, arise out of both social and medical problems met by action-oriented personnel vis-à-vis consumers of services.

Since the 1960s I have held positions as a researcher in the city-wide system of mental health services in Washington and as a faculty member in an academic institution. At the same time, I have participated in programs and activities in the life of the Latino community, attempting to respond to rapid changes in the city and the concerns of members of the Latino group.

This particular study grew out of selected aspects of my work in the Latino community of Washington. That work focuses on two areas: (1) educational and consultative activities among practitioners and decision-makers interested in the relation between a knowledge of Latin American cultures and successful program development; and (2) advocacy in a walk-in free medical clinic located in the Spanish-speaking community of the city and related work with various types of caregivers in the city.

The upsurge of governmental and public interest in the life styles and problems confronting the growing number of immigrants in the Washington metropolitan area has been demonstrated by an increase in local and national meetings convened to focus upon the characteristics of the Latin American population and to develop strategies for action. On countless occasions I have worked with city officials, agency administrators, health care practitioners, and members of special interest groups in their quest for information which would help in the design of plans and programs to serve the Hispanic population. As a result, I have been able to focus some attention on the relationship between the cultural information they request and their action-oriented concerns.

Participation in the resurgence of ethnic consciousness among Latinos in Washington has meant that, in addition to my regular responsibilities as a university professor, I work part of the time in a world which extends beyond the boundaries of traditional university life. A clear effect of these activities has been that this research about Latin American immigrants is an outgrowth of questions derived from direct observation and practice. In selecting research areas for the present study I have drawn upon my own work, particularly as it relates to the extension of health and mental health services to Latinos.

Early in 1968 I helped a physician to organize a once-a-week free walk-in medical service for Latino immigrants. This clinic is unique among such facilities in the city because it does not have eligibility requirements; it serves as a first-stop facility for persons with varied types of health complaints. The patients are typically residents of the Latin community, including those with limited resources, transient visitors, and others, such as illegal aliens. The clinic is located in a well-known multiservice agency under private auspices which offers orientation to newcomers as well as other programs such as counseling, advocacy, and special education.

Several interrelated dimensions of my work in this clinic spurred my interest in the present research. Outside the physician's office, I frequently took initial histories of the prospective patient's view of his or her problem. Within the examining room, I listened to the physician's elicitation of medical histories and served as an interpreter for patients with limited fluency in English. I assisted the physician during examinations and, afterwards, patients frequently told me their perceptions of the prescriptive medical orders.

Referrals to specialists or to clinics for follow-up led to work with various types of community resources to insure their availability for the particular problems of the Latinos. Part of my follow-up activity also included offering counseling services to persons who faced crises which were difficult to resolve with the limited resources of established community caregivers.

Descriptions of the history and nature of specific problems and of paths towards their cure offered a stimulus to study systematically the Latino concepts of disease as these are expressed in modern scientific biomedical contexts. There was evidence of the tenacity of beliefs and attitudes derived from the body of traditional medicine of Latin America. There were, thus, many classic expressions of the "hot" and "cold" syndromes, as well as association of psychological malfunctioning with causes such as *aire* (air) or *cóleras* (anger). Nevertheless, observation indicated that these and other folk concepts were also meshed with beliefs and practices of the scientific medical traditions found in both Latin America and the United States. It seemed that a focus of central importance for research should be a careful description of ways in which the multicultural body of Latino medical tradition manifested itself in concrete form during episodes of illness.

An area of related interest was the relation of physical symptoms and psychological distress. In detailed preliminary descriptions of their problems, Latinos frequently presented such concerns as family problems, anxiety about bad news from absent relatives, or crises related to job tenure. Some linked troubling interpersonal relations such as marital problems with the recurrence of physical symptoms. Others searched for upsetting emotional states within themselves as explanations for the onset of disease. For example, feelings of anger over unfortunate events were sometimes viewed as explanations for disease of the joints or for certain digestive disorders.

Linkages between various emotional states and symptoms of disease appeared to have high recurrence. Not infrequently, however, Latinos who associated behavioral dimensions with physical conditions did not discuss these relationships with the physician. Moreover, my observations in examining rooms suggested that during the course of a medical interview physicians did not, as a rule, elicit behavioral problems. This apparent problem was one of possible investigative interest and I paid increasing attention to the process of communication between physicians and Latino patients in several types of health care settings. Common language was clearly a factor involved in effective communication. Yet another dimension was the caregiver's concept of his or her role as a diagnostician. Physicians, who carry primary responsibility for the establishment of diagnosis, follow lines of questioning which encourage a patient to describe symptoms of discomfort or pain. However, they do not usually elicit the patient's conceptions of etiology; that is, the *patient's* version of the reasons for the existence of disease.

Typically, physicians ask patients to present the *problem* or *complaint* -- for example, "pain in the stomach," "loss of breath," or "persistent burning sensation at urination" -- and they ask subsequent questions to elicit the details of symptomatology which are necessary to establish a working diagnosis. Routine physical histories do not tend to include the patient's conception of the problems which are believed to have precipitated an incident of illness. Physicians assume that it is their role, rather than the patient's, to interpret the nature of the problem. Thus, for me, a resulting issue of interest was to determine just how patients syncretize their understanding of explanations offered by professional caregivers with their own concepts of the problems.

Upon examination of literature related to these topics several gaps became evident. Anthropological research investigating Latino concepts of disease offers rich material about traditional concepts of disease, diagnosis, and curing.[1] However, there is only a limited body of literature which explores the linkages which Latinos make between various indigenous traditions during the processes of consultation with scientifically trained practitioners.[2] This gap in our knowledge contrasts with the body of available materials on the use of traditional healers.

With regard to the influence of social and cultural dimensions on psychiatric disorders, few epidemiological studies of psychiatric disorders are known to have been conducted among Latin Americans[3] or among Latinos in the United States.[4] Studies of the concept of culture and stress among working populations of Latinos and Latinas in urban environments are few. This is the case despite the fact that the general literature on the sociocultural factors associated with stress has increased considerably over the past few decades.

The combination of perspectives derived from my varied activities led to a preliminary research project whose purpose was to identify culturally defined concepts of disease prevalent among Latin American immigrants. This resulted in the development of a health history inventory, which is the instrument used in the present investigation for the elicitation of problems concerning disease, the use of practitioners, and patterns of curing.

AIMS OF THE RESEARCH

While a specific aim of the research was to examine Latino perceptions and interpretations of the problems of disease, a complementary one also existed: Identification of social and cultural factors and of personality reactions. A number of cases appeared to suggest that

Latinos frequently use general health agencies rather than mental health facilities during times of behavioral distress, although the distress was not usually discussed during the health interviews with practitioners.

An outgrowth of my awareness of the need for assessment of relationships between sociocultural factors and levels of stress, was the development of a second specific research aim. During the past three decades the field of mental health has been subject to burgeoning interest in epidemiological analysis to determine correlations between overall symptom scores and selected characteristics of population groups. These data have broadened our knowledge about the etiology and distribution of mental health problems. To my knowledge, however, there have been few efforts either to undertake such studies among people of Latin American heritage in the United States or to identify instruments which might be feasible for such study.

Therefore it became a specific aim of this research to measure levels of stress and to correlate stress scores with such sociocultural characteristics as age, occupational levels, marital status, and sex. In approaching this aspect of the study, the writer was influenced by the work of A.H. and D.C. Leighton and their colleagues in the Stirling County study[5] which suggests that the development of symptoms of psychiatric disorder is a result of interference with a person's strivings for the satisfaction of certain basic needs; this interference may originate within the individual or from external environmental forces. The development of symptoms during attempts to cope with distress is common. Psychoneurotic and psychophysiologic symptoms such as anxiety, depression, pounding heart and "stomach troubles" have been found to be frequently exhibited by people who suffer mild emotional upsets.[6] Thus, identification of high-risk and low-risk groups has theoretical implications and may provide important knowledge for the extension of mental health services to Latinos.

The third aim grew out of a concern with strategies and mechanisms which Latinos use to cope with their problems. A necessary complement to the investigation of differences in stress levels among Latino groups was the identification of characteristic ways through which individuals reduced conflicts between their strivings and the demands of their environment.

Carmen Fernandez and I have identified conflict-reducing mechanisms of Latino-born children who have faced the socializing demands of both the Anglo-based educational system and the Latino-based home environment.[7] Children who incorporate the learning of two languages and two cultural systems with almost equal proficiency often rely on the mechanisms of *compartmentalization*. They segment their perceptions and

and feelings, separating those associated with members of the host society from linkages with their family or Latino friends. They live in two worlds, cushioned from areas of conflict in values.

Not all children, however, can use this defense effectively. Some young immigrants tend to reject their cultural heritage and to rapidly seek out Anglo role models. They do not appear to respond to the efforts of parents, educators, or ethnic-consciousness groups who try to help them to retain their Latino heritage. These children actively rely on the mechanism of *identification* with representatives of the host society.

Examples drawn from the experiences of Latino children served to underscore the need to understand how Latino adults deal with conflict. Research to identify the mediating mechanisms which adults use in conflict resolution could contribute to an understanding of their expectations in the socialization of their children. I, therefore, focused on the identification of prevalent patterns of conflict resolution followed by Latinos as they met and dealt with tensions and obstacles in the family or with "significant others." Values and norms used as criteria for the resolution of conflict were abstracted from specific "trouble cases."

To recapitulate, the research objectives represented three levels of specific inquiry:

1. Study of beliefs and perceptions about disease and the practices followed in the management of illness. This focused on the world of *inner meaning* of the immigrants as they incorporated and interpreted concepts from the multicultural systems of which they were a part.
2. Identification of levels of stress by socio-cultural characteristics. This dealt with the influence of *environmental* forces on the responses of Latinos to crises.
3. Examination of patterns of conflict resolution. This concentrated on linkages between *values* and *norms* and the strategies used to handle problems.

THE STUDY POPULATION

The total of ninety-seven respondents included seventy-one women and twenty-six men. The population was drawn from two sources. The first was a group of known seekers of health service from a multipurpose community center. The second was composed of the parents of children from the two schools in the city with the highest proportion of Spanish-speaking children.

Over half (53.1 percent) of the school parents had been in the United States six years or more, while only 16.7 percent of the community sample had been in the

United States for that length of time. Whereas most school parents were permanent residents or U.S. citizens, 41.7 percent of the community respondents were illegal aliens.* The two individuals with the longest period of residence in the country were a woman migrant worker who had first entered in 1953 and a retired woman who entered that same year.

For purposes of comparison, the health status of the second group was unknown prior to research. The school parents were selected for comparison because they were assumed to be a more stable population than the community respondents.**

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*Immigrants are persons admitted to the United States as lawful permanent residents. A nonimmigrant is a person who enters the country for a temporary period. According to the Immigration and Naturalization Service this group includes "diplomats and their families, attendants, servants, and personal employees; visitors for business or pleasure; persons transiting the United States; treaty traders and investors; students; representatives to international organizations and their families, attendants, servants, and personal employees, and others." (U.S. Immigration and Naturalization Service, *Annual Report*, 1974, pp. 2-6).

The illegal alien is a category which includes: those who enter through border points without proper papers; visitors or students who overstay the terms of their nonimmigrant status; or seamen who desert ship. (*Ibid.*, p. 15). The usual Spanish word for this category is *indocumentado* (without documents).

Persons who apply for U.S. citizenship tend to be those who have had the required five years continuous permanent residence in the United States and the spouses of United States citizens. (*Ibid.*, p. 19).

**One of the schools was a public school, and the other was parochial. Forty percent of the children in the parochial school were from households with parents of Latin American origin; 53.4 percent of the children in the public school were of similar origin.

The group of known seekers of service, hereinafter called the community group, was composed of forty eight individuals (fourteen males and thirty-four females). Almost all had sought health care from the community center in the fall of 1973. They represented the entire group of patients from El Salvador and Colombia who had sought health care in this period, plus a randomly selected number from adjacent countries. A group of ten domestics was included in this community sample because of my special interest in the condition of women with children who work as live-in domestics.

The forty-nine school parent respondents were chosen by random stratified sampling, to match the country or area of origin of the community group. The school group included twelve males and thirty seven females (Table 1-1).

The age range of both groups together was from 18 to 65, with over two-thirds (74.2 percent) in the age group of 30-49. Slightly over 10 percent were in the 15-29 age group, while 14.4 percent were 50 and over.*

Over half of the immigrants were from Central America (57.7 percent, from El Salvador, Guatemala and

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*It is the author's impression that the recent migration of Central and South Americans to this country has been initiated by a high proportion of women and men who have entered the phase of parenthood. However, these observations should receive more definitive corroboration in the forthcoming census enumerations.

TABLE 1-1

IMMIGRANTS' CHARACTERISTICS: BY GROUPS, SEX AGE, ENGLISH-SPEAKING ABILITY (IN PERCENTAGES)

Attribute	Percentages
Sex	
Males (n=26)	26.8
Females (n=71)	73.2
Respondent Group	
Community Group (n=48)	49.5
School Group (n=49)	50.5
Ages*	
15-24	3.1
25-29	8.3
30-34	24.7
35-39	22.7
40-49	26.8
50-59	10.3
60 and over	4.1
English-Speaking Ability**	
Speaks none	17.5
Speaks fairly	54.6
Speaks well	26.8
Unknown	1.0

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*Analysis of the age groups between 25-40 by five-year intervals was based on the original assumption that most respondents would fall in these categories. I had expected to find few respondents in the 40-and-over groups; so I used 10-year intervals.

**Immigrants were asked to rate their own English-speaking ability in relation to their perceived ability to make themselves understood at work or in other commonplace activities. This did not include reading or writing ability.

Nicaragua), and approximately one-third came largely from the Andean area of South America (34.0 percent from Colombia, Venezuela, Ecuador, Peru, and Chile). The rest (8.2 percent) were from Mexico, Puerto Rico, and the Dominican Republic. The choice of persons from the selected countries was based on the proportions from Central and South America estimated for the Washington Metropolitan area, as well as on trends in immigration from those areas for the country as a whole.*

Slightly over half of the group (54.6 percent) reported a "fair" English-speaking ability, and one-fourth (26.8 percent) stated that they spoke the language well.

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*Data on permanent residents and other than permanent residents from the U.S. Immigration and Naturalization Service, Address Report Cards (Form I-53) for the years 1971 and 1973 show the composition of the Latin American population for the Washington Metropolitan area, by country of origin. Cubans were twice as numerous as those from any other Latin American country, particularly in the suburban parts of the area. Colombia, Peru, and Ecuador were the South American countries with the largest proportion of immigrants, while Guatemala and El Salvador were the Central American countries with the largest representation. The concentration of Central and South Americans from these countries in Washington is similar to national data on residents from these areas. In 1974, El Salvador and Guatemala, and Colombia, Argentina, and Ecuador were the countries from this part of the Western Hemisphere with the highest numbers of residents in the United States (U.S. Immigration and Naturalization Service, *Annual Report*, 1974).

It should be noted, however, that entry to the United States from Mexico and from the Spanish-speaking nations of the Caribbean (e.g., Cuba and the Dominican Republic) is proportionately larger than the movement from any individual Central and South American nation. In addition, none of the above-cited proportions includes figures on the entry of undocumented aliens.

The remainder (17.5 percent) did not speak English at all (Table 1-1). Of the total group, one-third had received some specialized English language training in the United States, most of which had been in private language academies or in courses organized by private community agencies or in government-sponsored programs.

METHODOLOGY

The specific aims of the research called for three types of data and the methods utilized reflect these foci. Background information, material about entry and settlement, and data on the problems of disease, required quantitative and qualitative approaches. These data were gathered through the structured and open-ended questions included in the schedule. The body of information on mental health status was elicited through the twenty question Health Opinion Survey. Materials for the study of conflict were chosen from the follow-up study of forty immigrants and their significant others. Ways of life of the immigrants and their problems were studied through participant observation in a number of selected situations and through semi-structured interviews. Details of methodology are presented in the following sections.

The Three-Part Schedule

In a pilot study conducted just prior to this research, as well as during a period of more intensive field work, I had explored ways to study sociocultural aspects of stress and disease at a single point in time. A three-part schedule, including items on sociocultural components, biomedical information, and behavioral aspects, was developed and field-tested. This schedule became a major data-gathering instrument for the present study.

The first part of the schedule contained forty questions regarding demographic and cultural characteristics particularly in the area of family structure, socioeconomic status, and work experience. Additional data were gathered among parents with children left behind in their country of origin.

The second section was the health history inventory, which sought data about health problems among respondents and members of their households at the time of the study. The participants were also asked about their experiences with twenty-four illnesses which I had found to be areas of special concern among respondents who had participated in the pilot study. In descriptions of disease, immigrants were asked to identify or describe the problem, its course of development, types of caregivers, and curing approaches.

The third part of the schedule focused on the identification of stress. Since I have special interest in the measurement of levels of stress, and in types of low-risk and high-risk life situations, I consulted experts in the field of social psychiatry to make inquiries about instruments which could be adapted for use among people of Latino origin. The most feasible instrument appeared to be the Health Opinion Survey (hereafter called the HOS), which had been constructed for use in the Stirling County study of psychiatric disorder and sociocultural environment.

There are relatively few studies of either treated or untreated psychiatric disorder among Latin American populations. I hoped that the present investigation would offer a basis for assessment of some of the issues involved in the adaptation of this instrument to the study of stress levels among members of such a population. For purposes of the present study, in consultation with other collaborators, I translated the twenty-item HOS. The translated versions were field-tested among persons with national backgrounds similar to those of the respondents in the study and among a small group of health caregivers from these same countries.

With one exception, all interviews were conducted in Spanish by me and the two collaborating interviewers.[8] Contacts with respondents took place in a variety of locales in Washington, D.C. or its suburbs.

The Case Studies

A group of forty immigrants from the total sample was studied over the period of one year, with the aim of developing a more detailed understanding of their way of life. Of particular interest were their perspectives about ongoing problems of disease and its management, and about the resolution of conflict. During the course of the year, additional information came from contacts with immigrants as I participated in joint activities with them. These included such endeavors as sharing meals, visits to the home of relatives and friends, participation in festivities, and joint shopping trips. I was asked for assistance in such areas as translation of documents, real estate and legal transactions, the interpretation of current events in politics, and visits to medical care specialists. Cases of medical emergencies and family conflicts were further discussed with me. These activities offered a basis for detailed study of health beliefs and the cure of illness which I had originally discussed with them in the health inventory and the HOS.

Observation in places of work and in health settings also permitted me to study cycles of activity and their general social environment. Interviews with health professionals and work "bosses" offered special insights for understanding their viewpoints of Latin American immigrants.

By personal contact and through telephone conversation, I asked selected caregivers, who carried the immediate responsibility for the provision of services to respondents, for their impressions of respondents and their problems. Conflicts and the patterns followed in their resolution were studied within the particular situation.

During the summer of follow-up, I visited selected communities of origin and the families of fourteen respondents from Colombia and El Salvador.* Visits were arranged by the respondents prior to my arrival. I talked to returned immigrants in their home communities and visited with the families and friends of Washington residents, to gain insight into the ways of life in their areas of origin. Observation and interviews with health professionals in small towns as well as in metropolitan centers offered perspectives on the changing nature of health care delivery in Latin America. Field work in these settings provided material for comparison with the viewpoints about health care in the United States held by the immigrants studied in Washington.

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*It should be noted that I have longstanding interest in Colombia, demonstrated through work experiences in the country and research in areas of culture change, medical care, and ethnohistory. I was born in Costa Rica and I have kinship ties in El Salvador. This field trip constituted my third visit to El Salvador.

Consent for the Conduct of Research

A study which relies on a combination of research approaches requires consideration of ways to elicit the interest, collaboration, and consent of respondents and of their networks of significant others.

I sought and obtained written permission from school authorities and appropriate agency administrators to conduct research within their organizations. Moreover, at the time of initial contact with school parents, the interviewers carried letters of introduction from the schools and copies of the letters which the principals or their designated representatives had sent to parents (See Appendix A). These letters, written in Spanish and with an English translation, explained the general purpose of the investigation and assured respondents that they were free to accept or refuse the invitation to contribute to the research. (A more detailed description of the process of seeking permission to conduct research is found in Appendix B.)

Community respondents, who were drawn from a health center population, were asked directly for their voluntary participation in the study. Since the research might have been easily associated with the regular activity of the center, as well as with my own work in the community, I was careful to note any "polite" indications of assent which could have represented hesitation or refusal. Throughout the research I kept confidential certain information as requested by respondents such as illegal aliens or their friends.

The field work with selected respondents and their families in Colombia and El Salvador was undertaken through introductions and contacts in Washington. Visits to formal health organizations in these countries were made with the assistance of national, regional, and local health officers.

Data Recording and Analysis

Interview data were recorded on the schedule and on Unisort Y9 cards. All interview and field materials were kept in locked files in my office. Data were accessible only to me and the research staff.

Data from the schedules were coded and punched on data analysis cards. There were seven cards per person. Computer analysis of frequency distributions and the means calculated for the HOS were done on a PDP DECsystem-10 computer.

The field data and related documentary material were content-analyzed to permit the identification of themes of central relevance for the major subject areas. Detailed case-by-case analysis offered a rich source for the study of the processes through which the immigrants adapted and faced their problems of health maintenance and illness.

The scoring of the HOS was done according to procedures recommended by those who had done the Stirling County studies.[9] The method is described in Chapter 7 of this book.

Preliminary analysis of the HOS by demographic characteristics was followed by comparisons of scores between samples. Analysis of high, medium, and low-stress categories offered a basis for more specific identification of differences according to levels of stress.

ORGANIZATION OF THE MATERIAL

The book is organized as follows. Chapter 2 will offer a review of selected literature on Latin American popular medicine. The second part of the chapter presents conceptual approaches for the study of sociocultural influences on behavior, with special emphasis on psychiatric epidemiology and conflict-solving mechanisms. In Chapter 3, I shall describe the processes of entry and settlement of the Latinos in the study, focusing on the organization of household and family, since domestic units are major contexts within which health is defined and problems of illness are managed.

Chapter 4 will have findings on work as a central linking experience of the immigrant with the host society, exerting differential influence on the careers of Latino women and men. Data about patterns and types of work and cultural values will offer a basis for my discussion of the disjunctions between aspirations about work and the Latino patterns of coping with job-related stresses.

Findings about the most frequently identified health problems will be found in Chapter 5. Types of reported symptoms influence the patterns of management and treatment within the household and in consultation with intermediaries from popular and professional medicine. In these contexts, I shall discuss special issues in communication between medical practitioners and patients, with focus on cross-cultural aspects and the nature of the physician patient relationship.

In Chapter 6 four commonly found syndromes of illness will be described: disorders of the blood, disorders of the heart, digestive and genitourinary problems, and diseases attributed to the hot/cold theory. These syndromes reflect the multicultural character of Latin American popular medicine. Sociocultural and demographic conditions which influence levels of stress will be highlighted in quantitative findings about psychiatric symptoms, as found in Chapter 7, which also presents high or low levels of stress for such categories as age groups, socioeconomic levels, sex, and household organization. Qualitative aspects of the management of stress will be described in Chapter 8 through focus on the mechanism of *controlarse* (control of the self). The behavioral problems of boys and girls and conflicts between men and women in conjugal relations offer a basis to examine prevalent conflict-reducing mechanisms and some of the problems in using them as Latinos deal with the changing conditions of their lives.

CHAPTER 2

LATIN AMERICAN POPULAR MEDICINE AND THE STUDY OF STRESS

Anthropological study of concepts of health and disease has grown out of a research tradition which covers a broad spectrum of human life. Pearsall states that medical anthropology encompasses the total range of human experience -- biological, psychological, social, cultural, and ecological -- as this bears on adaptation to disease and the maintenance of health.[1] The concept of health reflects man's continuous attempts to change and to control the environment. According to Hughes, among most people health is seldom narrowly defined as a concept of perfect well-being of the individual body.

> In many groups man is conceived to be continuous with both the social and non-social aspects of his environment, and what happens in his surroundings affects his bodily well-being. Not only a person's own actions, therefore, but also those of kinsmen or neighbors can cause sickness.[2]

Hughes also points out that, when we speak of health and well-being, we confront persistent problems of adaptation and equilibrium. For life reflects "continuing constellations of adaptive processes, and disease represents an exaggerated or abnormal use of defense reactions or mechanisms on the part of the organism in its attempts at adaptation to threatening circumstances either internal or external."[3]

LATINO CONCEPTS OF DISEASE

Anthropological research among the peoples of Latin American heritage shows that concerns about states of health and disease constitute major controlling forces in their lives. Surveys and field studies in Indian communities, in mestizo settlements, and in low-income urban areas indicate that ill health is a source of constant concern in households, since members frequently suffer from illness. Accidents, muscular aches, nutritional deficiencies, or endemic problems associated with inadequate community hygiene contribute to this reality. Tensions associated with the threats of the loss of parents or unexpected strong emotional experiences also lead to threatening psychological conditions.[4]

That Latino concepts of health and disease have central sociocultural significance has been noted by students of the culture, as illustrated in the following passage by Samora.

> Health, as a state of being, in its two aspects, being ill and being well, is one of the most important value orientations in the life-ways of the people. It appears with regularity in all institutional contexts. In particular, those beliefs and attitudes related to or expressed in religious, familial, and economic behavior

> patterns express in a variety of ways the importance of health. There is strong affect associated with the polar states of being well or being ill. The cultural forms associated with health are greatly elaborated. The idea of health, then, pervades the culture. The conventional greeting, "how are you?" (*Cómo está?*) has real health meaning; the response is likely to be an account of the respondent's state of being, as well as the state of being of those close to him.[5]

Beliefs about health and illness hold a central place in social relationships within the Latino household and in relations with other significant groups. These concepts are part of the system of social control. Concern about states of disease are learned from early childhood onwards and exercise a continuing influence among adults and in the events which give direction to their lives. G. and A. Reichel-Dolmatoff note this from their detailed study of Aritama, Colombia.

> Since infancy the individual has been taught that illness forms an essential part of life. To a large degree the daily "dos" and "don'ts" of child training refer to the avoidance of illness, and every child is used to seeing ill people, hearing their ailments discussed by others, and listening to their own descriptions of symptoms and treatments. The education *by* fear and *to* fear makes constant use of the specter of disease as a controlling force which may strike at any moment. In reality, the controlling power of society is illness and all moral law enforcement is accomplished through the menace of disease. But the child is not only given to understand that such exterior influences as a rain shower, a drought, or a certain food might cause ill health; he is also taught, explicitly or implicitly, that rage, joy, sudden fear, or prolonged sorrow might lead to organic dysfunction.[6]

In studying the principal features of popular medicine* in Latin American communities and among Latinos in the United States, most researchers indicate that there is no single integrated Latino theory of disease. Latin American popular medicine is eclectic in nature. An important characteristic of this belief system is its capacity to assimilate practices from various popular and biomedical traditions. The indigenous beliefs, Spanish medicine based on ancient and medieval concepts, spiritualism, patent medicine, homeopathic therapy, and the professional biomedical traditions are combined to form a dynamic system. Commonly held etiological concepts and the use of diagnostic resources and curing approaches tend to reflect this multicultural character.[7]

For example, a rural midwife, whose practice is based on magical medicine plus her own experience, may give an expectant mother a dose of quinine to accelerate labor, or she may inject special doses of *pituitrina* (pituitrin ampules) for the same purpose.[8] Drugstore

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*The terms "folk medicine" and "popular medicine" have been used interchangeably by researchers to refer to medical systems of indigenous rural and urban lower socioeconomic groups. Richardson and Bode state that popular medicine is the medicine of the populace, particularly the part that belongs to the lower economic section. Its scope includes available medical facilities, patterns of healer-patient relationships, and the concepts of illness and health. These authors consider popular medicine as "an adaptive response to a social environment produced by the intersection of urban and social features." (M. Richardson and B. Bode, *Popular Medicine in Puntarenas.* Costa Rica: Urban and Social Features), p. 253.

preparations and patent medicines are popular in some areas, while sulfa drugs and penicillin, available over the counter, are self-prescribed for a number of conditions.[9]

Magic and Disease

Magical ideas, empirical categories, and strong emotional states are the most commonly cited Latino beliefs about causation of illness. Diseases of magical origin are those in which causative factors lie outside the realm of empirical knowledge and cannot be easily verified, while empirical or natural causes are those in which known external factors operate directly on the organism to produce illness. Diseases of psychological origin are frequently those in which strong emotional states lead to susceptibility to illness or to actual organic dysfunction.[10]

One of the most common diseases of magical origin described in Latin American popular medicine is the evil eye (*mal de ojo*). Symptoms of this illness generally become evident in small children, although it is sometimes seen among adults who are in a weak or vulnerable condition. The power to cast the evil eye may be voluntary or involuntary. It is transmitted usually through an admiring glance at the object. For example, people who admire an infant with a strong glance may be the agents of illness.*

The most commonly found effects of the evil eye are listlessness, weakness, diarrhea, and fever. Preventives used to counter the effects of the evil eye include amulets and special protective coverings. Cures include herbs, drugstore remedies, and magical treatments, as with eggs,** to diagnose and draw out evil.[11]

Diseases of Natural Origin

Frequently mentioned diseases of empirical or natural origin are those of hot and cold imbalance, of gastrointestinal obstruction and dislocation of the internal organs, and of the scientific biomedical categories of disease.

The Hippocratic doctrine of four humors, brought to the Americas by the Spaniards, is the source of the belief that the qualities of hot and cold found in nature lead

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*Students of Latin American concepts of disease state that belief in the evil eye in the New World is part of the heritage from the Spanish and Portuguese. The belief appears to have diffused to the Iberian Peninsula through Arab contact, or it may represent earlier influences. It should be noted, nevertheless, that the idea is widespread and prevalent. According to Ellworthy, Plutarch said that certain men's eyes are destructive to infants and young animals. The Finns, Lapps, and Scandinavians are reported to have been firm believers in the evil eye. Natives of India had practices to protect themselves from the possibility of casting, as well as being victims of, the evil eye. (F.T. Ellworthy, "Evil Eye," pp. 608-611.) See also C. Maloney, (ed.), *The Evil Eye*.

**In Central America and Mexico, diagnosis and cure of the evil eye may be done by stroking or "cleansing" a patient with an egg. (Isabel Kelly, *Folk Practices in North Mexico*, p. 120.)

to a variety of illnesses.* These qualities may have nothing to do with actual physical temperature. Certain foods, herbs, and beverages are classified as "hot" or "cold." Illness is often attributed to an imbalance between heat and cold in the body, and curing is accomplished by the restoration of proper balance.[12] Distinctions are made between these hot/cold qualities and the actual contrasting hot and cold temperature which may also lead to illness. Sudden changes in environmental temperatures, in particular, may make a person vulnerable to currents of air, commonly called bad airs. These enter the openings of the body and lodge there, resulting in aches, pains, and malfunctioning in the area affected.[13]

Gastrointestinal obstructions are suspected in concerns about a "dirty" or bloated stomach which needs cleansing so that food may pass to the intestines.[14] Diseases of the dislocation of internal organs or loss of muscular control can be associated with various causes, including exposure to certain phases of the moon or emotional trauma. With the diffusion of knowledge from the scientific biomedical tradition, Latinos may seek assistance to learn whether pathological agents such as microbes, amoebas, or parasites cause symptoms of gastrointestinal dysfunction, signs of weakness, or the presence of unusual masses.

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*Greek humoral pathology was brought to Spain by the Moslems. This doctrine assumes that the human body in a state of health contains balanced qualities of the four "humors": blood, phlegm, black bile (melancholy), and yellow bile (choler). Each is characterized by a combination of heat or cold with wetness or dryness. Foster and Rowe point out that in the New World this Hippocratic classification has undergone some changes. For example, substances were classified as hot or cold, or wet or dry, and each attribute was graded in intensity on a scale from one to four. In contemporary times, the wet-dry concepts and the scale of degrees have not been reported for any Latin American area. (G. M. Foster and J. H. Rowe, "Suggestions for Field Recording of Information on the Hippocratic Classification of Diseases and Remedies," p. 1.)

Strong Emotion as a Cause of Disease

The idea that strong or sudden emotional experiences produce physiological results is a concept widespread among Latin Americans. Anyone can undergo experiences such as anger, fright, shame, or disillusionment and, as a result, become more susceptible to illness or to serious incapacity. Jealousy and anger may lead to the onset or recurrence of *bilis* (biliary disorder), while certain types of fright (*susto**) may be associated with incapacitating physical and psychological symptoms.[15]

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*The Spanish word *susto* means a sudden frightening experience. Some years ago John Gillin described the syndrome of "magical fright" which was known in Spanish as *susto* or *espanto*. He emphasized the need for clarity in translation of the terms and in understanding their connotations. The group of ailments in this category are not just any ordinary fright, as noted in the following excerpts from the work of this author. The words *espanto* or *susto* mean fright, "but they are used in two different types of context. On the one hand, they are used to describe 'ordinary' incidents which involve fear but which do not affect the 'soul' -- that is, they are not believed to have serious psychological consequences. For example, one may be 'frightened' by the prospect of rain before the harvest is completed . . . In the second type of context, however, *espanto* and *susto* always refer to an illness or abnormal condition of the body and personality. For this reason it seems best to render the latter concept in English by the qualifying expression 'magical fright.'" (John Gillin, "Magical Fright," p. 402.)

Bilis, one of the more widespread of these conditions, has been cited by researchers in a number of Latin American countries and among Latinos in the United States.[16] Richardson and Bode noted that a sudden unexpected flow of emotion inside the individual, such as the unexpected appearance of a friend or an enemy or witnessing the death of a close relative, may affect the digestive work of the liver and result in serious illness.[17] Kelly was told that this overflow of bile manifests itself in stomach aches. After experiencing a rage, the subject may also have revulsion to food.[18]

Susto is associated with such symptoms as sleeplessness, diarrhea, fever, withdrawal from normal social activity and responsibility, nervousness, or depression.[19] *Susto* may or may not involve soul loss,* and this aspect does not appear to result in important differences in the syndromes of illness. A recent epidemiological study of *susto* in three Mexican villages shows that social role stress which derives from inadequate performance of role tasks is strongly associated with a process by which one defines oneself as *asustado*. Some of these findings suggest also that those who have experienced the syndromes

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*According to Adams and Rubel, soul loss in *susto* refers to the belief that the soul wanders away from the body of its own accord, usually while the individual is asleep but not necessarily while dreaming. The danger is that the individual may wake up while it is gone. Sickness and death will result if it is not brought back. Among non-Indian populations, *susto* without soul loss appears to be prevalent. (R.N. Adams and A.J. Rubel, "Sickness and Social Relations," pp. 346-347.)

of *susto* appear to have more severe organic symptoms than a group of matched controls.[20]

Many other strong emotional experiences may occur in association with the onset of symptoms of illness. Life experiences which cause loss of face, such as a husband's or a wife's desertion, may result in serious organic illness for the spouse left behind.[21] The unexpected discovery of a daughter's sexual liaison may contribute to the recurrence of longstanding digestive problems. Sensory experiences such as unpleasant sights may trigger off disturbing symptoms. It should be noted, however, that men and women who are subject to these illnesses may not consciously link emotional experience with their illness. Diagnosticians and curers are expected to assist with the identification of possible cause and to provide treatment. They search for ways in which disturbing sociocultural forces, emotional experiences, and organic factors contribute to the emergence of symptoms of illness.

Curing Patterns

With regard to patterns of curing, the urban areas of Latin America have a variety of healers. As noted earlier, curing frequently draws on a wide range of treatment sources, which may include herbs, over-the-counter medicines, patent remedies, and the prescriptions of physicians. Available literature indicates that the use of one type of healer and cure does not preclude another.[22] Researchers believe that patients do not categorize illness into those which home remedies cure and those which only a physician can treat. Although Simmons points out that certain diseases such as those in etiological categories of severe emotional upset and bad air are cured with popular means rather than with doctors' remedies, he suggests that this is related to the fact that these illnesses are usually ignored by scientific medicine. He states, in addition, that dichotomies between popular and modern medicine are not so simple to determine, in view of the fact that popular medicine offers cures for all the illnesses believed to be amenable to physicians' treatment as well.[23] This pattern is what Richardson and Bode describe as a curing strategy which makes for a wide-open maximization of available resources, as noted in the following illustration:

> Having decided, for the moment at least, to utilize human curers, (the sick person) can seek out orthodox physicians who operate as resident doctors in a charity hospital, as clinicians in a governmental clinic, or as private physicians in their own offices. He can request aid from members of the minor orthodoxy, the pharmacist, the licensed midwife, or her unlicensed colleague. He may go outside the orthodox and seek the heretic curers, the homeopath, or the naturist. Finally, he may shift from the human realm and call upon supernatural healers. Available to him are spirits, saints, and God.[24]

Given the presence of this complex system, a question of theoretical and practical relevance is: Just how does the definition and selection of healers and practices of medical care take place? For Latinos who become immigrants to an urban center such as Washington, what assumptions about the nature of disease guide their behavior as patients?

With increased recognition of the range of cultural alternatives available to members of ethnic groups in contemporary society, anthropologists need to study the fine-grain detail of ways through which the reconceptualization and reformulation of medical beliefs takes place as migrants face the specifics of illness in a new setting, and particularly the linkages between popular medical beliefs and practices and the scientific biomedical tradition. The theoretical and practical implications of such a focus have been highlighted by Fabrega and Firth. Fabrega has called for the generation of concrete information regarding clearly defined illness-treatment episodes, together with a presentation of the meanings and interpretations of these events to individuals or families. Detailed depiction of medical events is required in order to have a realistic awareness of the reciprocal influences that cultural factors have on illness and disease.[25] Firth states that knowledge of existing beliefs and practices in medicine is invaluable. But, he adds, one of the difficult questions to solve is this:

> Just what are the existing beliefs and practices which it is necessary to take account of (and by contrast, those which can be ignored or should be combatted)? It is often said nowadays that a medical man should learn "something" about the customs and beliefs of the people among whom he is going to work. But what precisely does he need to learn? An unsystematic collection of scraps of information may lead to an exaggerated respect for taboos and an underestimation of the importance of features of the society which may throw a medical program out of gear.[26]

Study of sociocultural conditions and illness events should thus permit a more systematic discovery of the knowledge which can be applied to action by health practitioners.

SOCIOCULTURAL INFLUENCES ON PSYCHIATRIC DISORDERS

A basic concern in the study of sociocultural influences on behavior has been the identification of factors in the environment which produce, encourage, or perpetuate psychiatric disorders. Conceptual approaches derived from the work of A.H. and D.C. Leighton *et al.*, have provided the background for my interest in this area.[27]

A.H. Leighton states that human beings exist in a constant state of striving to satisfy their basic needs. These needs include the following aspects:

> (A) Physical security, including food, shelter, and health; (B) Sexual satisfaction; (C) Opportunity to give and to receive love; to express hostility without reprisal; to gain recognition; and to express

> creativity; (D) Orientation as to one's place in society and the place of others; (E) Membership in a definite human group; and (F) Belonging to a moral order or system of values.[28]

Interference with these strivings may come from within a person or from his outside environment with various consequences: The person may try harder to overcome barriers; he may give up and withdraw; or he may develop symptoms as body, mind, or emotions reflect the lack of satisfaction.[29] The types of reactions which individuals show to interferences with need satisfactions depend upon various factors of life experience and specific stress-conducive conditions. The presence of noxious environmental conditions, the demands of critical events in the life cycle, or the discontinuities of changing cultural systems are factors in the environment which provoke reactions of stress.

The development of symptoms at some stage of the process of interference with these strivings is a common human reaction. The concept of symptom patterns refers to a classification of configurations or sets of disturbances reported by an individual who experiences them. They usually reflect some conflict and the individual's unsuccessful efforts to resolve these problems. A growing body of research on sociocultural factors and stress indicates that symptom patterns grouped under psychophysiologic, psychoneurotic, and personality disorder classifications are present among a large number of people.[30] There may be symptoms related to gastrointestinal, cardiovascular, and other organic systems or concerns, with or without chronic feelings of anxiety, depression, or self-depreciation. Included also are pervasive attitudes such as apathy, hostility, and suspiciousness.

The degree of impairment caused by combinations of symptoms in these areas may vary during a person's lifetime. But since, once present, these symptom patterns tend not to disappear completely (or to be more and more easily aroused), they are important "sources of danger." An understanding of etiological factors which contribute to the manifestation of symptom patterns is crucial, but it calls for careful descriptions and analysis because identical symptom patterns may occur as reactions to widely different conditions.[31] Meyer has emphasized that the most valuable determining factor of symptoms is "the form of evolution of the complex, the time and duration and circumstances of its development, and the character of possible transformations of the picture."[32]

Two interrelated areas are the subject of interest in the present research. The first deals with characteristics of populations which are associated with higher or lower levels of symptoms. The second involves the identification of patterns of conflict resolution which individual members of cultures are expected to use as they face tension-producing conditions in their environment.

Psychiatric Epidemiology

Epidemiological investigation is a basic approach used to study the influence of sociocultural environment on symptoms of psychiatric disorders. It focuses on the frequency of symptoms, their patterns, and their distribution. Through the study of incidence (new cases which occur within a specified period of time) or prevalence (the number of both new and old cases of a disorder present in a population group as of a specified point in time), it is possible to identify negative influences in the environment and susceptible points in the life cycle, as well as apparently supportive and protective circumstances, which bear on mental health status.

Hospital admission figures and other official records have been major sources of epidemiological study. These data necessarily reflect only "treated cases" rather than "true prevalence" (treated plus untreated cases). In contrast, community surveys enable investigators to determine how many members of a whole population (with some definite limits) have symptoms of the sort that indicate the presence of a psychiatric reaction, whether or not impairing to a "serious" degree, and whether or not receiving any professional treatment.[33] Three investigations which use a community base are of special relevance in the present research: The studies of Leighton *et al.*,[34] Meyers *et al.*,[35] and Karno, Edgerton, and other authors.[36] The writer has selected material from these studies regarding the linkages between levels of reported symptoms and various sociocultural factors.

Disintegration as Shown in the Stirling County Study

In the Stirling County study, A.H. Leighton and his colleagues[37] had a central interest in understanding relationships between sociocultural environments, individual basic needs, and reactions to interference with these needs. Indices of social disintegration* were used as guides to select maximally integrated communities within a rural county for comparison with maximally disintegrated areas. It was assumed originally that "severe social disintegration of a community produces both psychological stress and lack of resources for dealing with that stress; out of the resultant psychological strain, psychiatric disorder emerges."[38]

In analysis of selected findings, D. C. Leighton *et al.*,[39] show that the disintegrated areas studies had indeed many more people with impairing psychiatric

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*The indices of sociocultural disintegration included such factors as: extensive poverty, cultural confusion, high frequency of broken homes, few and weak associations, few and weak leaders, few patterns of recreation, high frequency of hostility, and weak and fragmented networks of communication. (A.H. Leighton, *My Name is Legion*, pp. 318-326.)

symptoms than the integrated communities. The symptom patterns indicative of psychoneurosis and psychophysiological disorder were much more prevalent in the disintegrated groups. So too were mental deficiency, sociopathic behavior, and personality disorder. The rarer forms of symptom patterns such as the psychoses, however, were found only in extremely small numbers in any of the selected communities; the difference in prevalence of psychosis by community type appeared to be no greater than chance would make it.

In a summary of the work on the integration-disintegration hypothesis, D. C. Leighton states that the most clearly noxious aspects of sociocultural disintegration appear to be those that affect the achievement of love, recognition and spontaneity, and the sense of belonging to a moral order and being right in what one does.[40] Such factors as the absence of warm interpersonal feelings and social supports which may accompany broken homes, a lack of belonging, and inadequate communication contribute to a higher prevalence of psychiatric disorder. For individuals in disintegrated communities, these noxious influences begin early in childhood and may continue throughout life.

In disintegrated situations, it appears as if choices are limited and there is little guidance for making them. Substitutions for unattainable objects and goals are difficult to attain. Persons who experience disturbing psychological symptoms in disintegrated areas appear to be likely to seek relief by following paths conducive to increased distress, since sources for prevention are weak or absent. Individuals may seek relief by withdrawal into daydreams, or they may experience increased anxiety or feelings of depression and apathy. Some may derive satisfaction from paranoid thoughts, while others may mask disturbed feelings through the increased use of alcohol.[41]

The Stirling County research illustrates how linkages between individual basic needs, role-specific life situations, and mediating support systems influence levels of symptoms in various population groups. In the disintegrated areas of the county, for example, the basic needs of the high-risk men and women were not adequately met by family groups or other supportive resources, and this contributed to the high prevalence of psychiatric symptoms for both sexes.

A finding of special interest was that the differential cultural situation of men and women in the two integrated communities appears to have influenced differences in their levels of symptoms. In the English community of Fairhaven, men's needs were apparently well met in consistency with the sociocultural system. Women in the same community, however, were experiencing role conflicts because they were aware of changes taking place in the role of women in the wider society, and they were not able to fulfill new interests and needs with satisfaction. They had the lowest self-esteem of all groups studied, expressing self-doubts and lack of self-confidence in their roles as mothers.[42] While new opportunities for work had become available for these women, they were ambivalent about entry to these jobs. The sight of a married woman at work caused some discomfort in the community.[43] These factors contributed to the higher prevalence of psychiatric disorder among women, as compared to men.

In the French community of Lavalle the reverse was true. Women continued to function comfortably according to previously established patterns, and the prevalence of psychiatric disorder among them was lower than both the country average and the average of the men in their own community. Women's needs here were evidently satisfactorily supplied. This community, much more than Fairhaven, had socioculturally based barriers against the incursion of change from the larger society.[44] Lavalle men, however, seemed to be slightly more impaired than Fairhaven men. These differences were based in large part on the differences in ratings of the over-60 men in both areas. Although the number of cases in these groups did not permit further analyses, it appears as if Lavalle men did not derive a strong sense of self-worth from their work as fishermen. At retirement these feelings may have increased.[45]

Support Systems and Symptoms of Disorder

The perception of support systems among the low-symptom groups, as contrasted with the high-symptom groups, has been discussed also in the work of Myers, Lindenthal, and Pepper.[46] Their research on social class, life change events, and psychiatric symptoms supports findings which have shown a significant relationship between social class and symptoms of disorder. In longitudinal research conducted in the catchment area of a community mental health center in New Haven, these authors found that lower-class persons are subject to more high-impact events of an undesirable nature[47] than middle-and upper-class persons. In addition, lower-class individuals experience more undesirable events which have a high re-adjustment or change impact[48] than do persons higher in the upper ranks of the status system. These conditions contribute to the higher prevalence of psychiatric symptoms in the lower class.

In interpreting these findings the authors state that, for persons of the lower class, economic want and associated indices of poverty contribute to increased strain. Fragile interpersonal relations among members of this group provide minimal social support as individuals face undesirable events which require coping. Symptoms might be viewed as cries for help which is not forthcoming.[49]

Lindenthal *et al.* studied perceptions of the systems of social support available to these New Haven respondents.[50] Their inquiry was based on the belief that one way to understand the interdependence of individuals within the social structure is through the identification of constellations of significant others to whom an individual turns when confronted with a crisis and in need of support. They classified two major sources of help: Primary supports (family and friends), and secondary sources (help for which one usually leaves home and pays a fee).

The authors learned that there was little difference between those with and without symptoms in their perception of the usefulness of primary supports, but 72 percent of the symptomatic subjects perceived secondary sources as useful, compared to only 44 percent of the asymptomatic.[51] The symptomatic were more likely to perceive formal resources in the community as helpful for a greater number of crises than did the asymptomatic.[52]

Stress in Latin American Communities

There are few known epidemiological studies concerning the incidence and prevalence of psychiatric symptoms among peoples of Latin American heritage in the United States or in Latin America. Among Mexican Americans in the United States[53] a subject of research interest has been the investigation of differences in the use of psychiatric facilities and the contrasts in incidence and prevalence rates between Latinos, Anglos, or others.[54] With the exception of the work by Madsen and Karno and Edgerton[55] most data have been based on patient populations.

Karno and Edgerton[56] elicited attitudes towards mental illness from a sample of over seven hundred Mexican American and Anglo American residents of East Los Angeles. Their original interest was to determine whether the reported underrepresentation of Mexican Americans in both private and public psychiatric treatment agencies could be related to their perceptions of, or attitudes towards, mental illness. At the time of their research, studies in Texas and in California had shown that Mexican Americans appeared to have a lower prevalence of major mental disorders.[57] Several interpretations had been offered for these findings.

On the basis of research in South Texas, Madsen had indicated that data about underrepresentation in that state could be interpreted through an understanding of the anxiety-sharing and anxiety-reducing mechanisms provided by the Mexican American family in stressful situations. According to Madsen, stressful situations among members of this ethnic group are less likely to produce mental illness because they are shared by the family group. *Curanderos* (folk curers) are resources available to the family, and they have therapeutic success. In addition, Mexican Americans do not worry about the possibility of mental illness as much as Anglos do.[58]

The Karno and Edgerton research showed that, although Mexican Americans in East Los Angeles were indeed strikingly underrepresented as patients in psychiatric facilities in California, they did not perceive and define mental illness in markedly different ways from Anglos.[59] A finding of importance was that at the time of the investigation, there was a paucity of formal psychiatric facilities in the area. Private family physicians were by far the most actively sustaining service in the community.[60] There was little evidence to suggest that the reported underrepresentation of Mexican Americans in psychiatric treatment agencies was due to the practice of folk psychiatry, because *curanderismo* had diminished in importance.[61]

With regard to the influence of the family on the patterns of management of emotional disorder, there was some evidence to suggest differences by acculturative status. Respondents who were born in Mexico and continued to use Spanish as their primary language believed that the recovery of mentally ill people *within* the family was desirable. Those who were born in the United States and who took the interviews in English felt, on the other hand, that the mentally ill *would not* best recover from their illness by staying with their family.[62]

Although Karno, Edgerton, and their colleagues were not concerned directly with the study of levels of impairing symptoms among their respondents, their research points to the value of identifying systems of support used by ethnic groups, in order to help to interpret data gathered from general patient population surveys. This work has contributed to an understanding of changing patterns of help-seeking as noted particularly in their data about decreased reliance on folk curers. Such knowledge is important because concern with the influence of cultural factors on members of ethnic groups should focus attention on the traditional qualities of their cultures as well as on the dynamic and changing aspects.

The findings highlighted in this section show that research which identifies linkages between the sociocultural environment and psychiatric disorder increases our understanding of etiology by drawing attention to the characteristics of communities which interfere with or provide for the satisfaction and fulfillment of basic needs of individuals in designated population groups. This does not mean that persons in integrated communities or those in the middle or upper classes who have lower overall rates of psychiatric disorder are free from stress. Overall levels of symptoms should be identified along with possible variations in subsamples, as in the case of the differences between men and women in the Stirling County integrated communities.

Findings regarding the functioning of systems of support within a community are important for efforts to understand the etiology of symptoms and the patterns for coping with them. For certain groups, the absence of sustaining "significant others" may increase the likelihood that at times of heightened stress, symptoms will develop or recur. Epidemiological study makes it possible to raise questions about the characteristics of both the high-risk and the low-risk groups. As increased attention is paid to the effects of desirable and undesirable life change events among the low-risk and high-risk groups in similar socioeconomic circumstances, we should be able to understand why it is that some do not succumb to noxious conditions while others develop symptoms of disturbance.

An issue of special importance in epidemiological research is the need to use, wherever possible, combinations of data-gathering approaches which can strengthen the interpretation of findings. For example, data about the decreased use of folk curers, the absence of psychiatric agencies in the community, and the use of family physicians by Mexican Americans in Los Angeles pointed to alternative explanations for findings about the underrepresentation of this ethnic group in official records. Leacock notes that community-based research is a most fruitful way to study the relation between social environment and psychiatric disorder. This requires that investigators use broad epidemiological techniques as well as complementary data-gathering approaches such as key informant interviews, household surveys, or in-depth case analyses.[63] The data gathered through these combined approaches provided the community context against which to evaluate epidemiological findings.

CULTURE AND PATTERNS OF CONFLICT RESOLUTION

As findings regarding indicators of stress have begun to emerge, a critical complementary dimension requiring attention is the process through which conflicts which result from interference with basic strivings are resolved. Conflict-solving mechanisms are guiding forces in the behavior patterns followed by individuals as they face the inconsistencies and contradictions of their lives. With the help of these mechanisms, individuals respond to the perception of a threatening condition, and they decide on potential avenues for its solution or mastery.[64] Culturally influenced conflict-solving mechanisms help to determine what strategies a given group of humans will use as they strive to anticipate and to master problems that arise in the various circumstances of their lives.

White points out that all behavior can be considered an attempt at adaptation, requiring strategies which range "from the simplest ways of dealing with minor problems and frustrations to the most complex fabric of adaptive and defensive devices that has ever been observed."[65] Adaptation does not mean either a total triumph over the environment or total surrender to it, but rather a striving toward acceptable compromise.[66]

The culture of any human group offers its members guides about what to do in the face of the problems and difficulties they encounter in daily life. Defenses, mastery, and coping are mediating mechanisms which help individuals to deal with major and minor problems of adaptation.* Each culture provides a framework to guide

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*Following White's definition, a *defense* is an "adaptive response in which present danger and anxiety are of central importance." *Mastery* is an adaptive response to problems having a certain cognitive or manipulative complex but which at the same time are not heavily weighted with anxiety. *Coping* refers to adaptation under relatively difficult conditions (R. White, "Strategies of Adaptation: An Attempt at Systematic Description," pp. 48-49.)

individuals as to strategies that should be used when men and women face problems. As Goldschmidt points out, man as an adaptive being has learned to cope with an environment not only in terms of technology and knowledge but also by means of institutions, values, attitudes, and manifestations of personality.[67] Differing demands and experiences in cultural systems may result in variation in the mediating mechanisms relied upon to resolve problems. As a result, for example, contrasts may be found in the ways in which different peoples express affect or emotionality, or in the extent to which direct or indirect action is used to resolve conflict.

Thus it would seem that, in this study of sociocultural factors and stress, knowledge of the characteristic ways in which Latinos cope with stress would permit a broadened understanding of the processes which contribute to vulnerability and symptom development among some Latinos and resilience and mastery over stress among others.

The magnitude and pace of change which Latinos face is not unique to them, for populations throughout the world today are participating in equally rapid adaptations within their own societies or in transnational migration movements. Yet these realities underscore the critical need, under such conditions, for understanding the psychocultural strategies which permit men and women to respond to symbolic and real transformations in their lives. The Latinos who succeed in their efforts to immigrate and settle in the United States attribute this to a number of factors such as the help of family members, careful planning, or good luck with immigration officials. But as Lifton and the Spindlers emphasize[68] the burden falls on the individual to establish guides for behavior and to master the difficulties of changing environments. An understanding of Latino strategies for resolving conflict permits a broadened view of the forces which contribute to their desired self-realization, as well as to impairment and symptoms of disturbance.

CHAPTER 3

ENTRY AND SETTLEMENT OF THE IMMIGRANTS

Entry into the United States is but one stage in a continuing cycle of adaptation and change for Latin American immigrants. Thus it is necessary to discuss the dynamic aspects of crossnational immigration and settlement among Latinos who participated in this study. Immigrants move across international boundaries and also within the city to which they come. Major changes take place in domestic units as families separate in order to facilitate migration. To follow this complex process, I have chosen to focus on the changes and realignments in households and families as evidence of the shifts involved in migration and settlement. Moreover, since the domestic unit is the major context within which health is defined and problems of illness are managed, at this point it is useful to consider the complex effects of immigration on the household.

As the immigrants settle in Washington, they establish nuclear or extended households. Even though some of these households do not resemble the forms they had in the country of origin, a strong pattern of interdependence among members of households is clearly in evidence. For some Latinos, the requirements of social life and the guiding norms and values of the host city of Washington call for fairly rapid assumption of new patterns in the organization of domestic units. Others take years before they reestablish the household type which had been familiar in Latin America.

Furthermore, the composition of a family naturally changes with developments in the life cycle as children grow up and parents grow older. Slightly over two-thirds of the individuals in this study were women, and most of them had migrated after they had begun to establish their households and to rear their children. If a woman is to act as leader in a chain of migration, she and many others must engage in careful planning, particularly as to the caretaking of children left behind and of those brought to Washington.

Settlement in Washington means that the immigrants become heavily committed to work for the advancement of their children and for help to parents and siblings. They hope that their children can join them in Washington, but even if they do not, financial help and counsel must be given during periods of crisis. As an example of the dynamics of entering and settling in Washington, I will sketch briefly the experiences of one family which cover a span of approximately seven years. I shall then present a detailed analysis of the population of my study as to patterns of entry, characteristics of the families, and compositions of households.

EULALIA MORA SETTLES IN THE UNITED STATES

Eulalia Mora,* a fifty-four year old immigrant from Central America, had first come to the United States in 1969 to visit two daughters and two sons who had preceded her and were living in Washington. In 1968 the elder daughter, twenty-eight year old María, had accepted an invitation to join friends who had come to work in Washington. Leaving her only child in the care of her mother, she entered the United States as a live-in domestic with an American family who helped her to secure a resident visa. She eventually married a man from another Latin American country; each spouse brought one school-age child by a previous marriage to their newly established household. Both Maria and her husband worked full time.

Helena, Eulalia's twenty-two year old daughter, arrived in Washington in 1968, a few months after María's entry. In order to come to the United States, she left her son (age 3) in Eulalia's care. Helena hoped to do well in Washington, so that she could eventually bring both her child and her mother to live with her. This meant that she would have to search for a job which would qualify her for entry as a permanent resident. In Central America, she had worked in various capacities, such as clerical and sales work. She had entered the United States with an A-3 visa, to work with a diplomatic family.* After her arrival she found that she strongly disliked the long hours involved in domestic live-in work. But although she wanted to leave this job, she stayed with it, because her visa limited her to jobs with families in the diplomatic category.

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*All names used in this book are pseudonyms. If the names duplicate those of real persons, living or dead, this is entirely coincidental.

Approximately a year after her arrival, Helena sought the services of a lawyer to facilitate her plans to apply for permanent residence in the United States. He gave her advice regarding the jobs in high priority, as listed by the U.S. Department of Labor, and helped to fill out various application forms which were required by this Department and by the Immigration and Naturalization Service.** For these services, the lawyer charged her $700. A few years passed before her application was finally processed. Much to her joy, in 1973, she was advised that her papers were ready. She went back to her country of origin to wait for the "call" by the U.S. consular officers who advise immigrants when they can reenter the country as residents. She was particularly happy because this would mean that she could bring her son to the States with her.

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*An A-3 visa is a category extended through the Department of State to persons such as domestics who work for families who are in the United States as diplomats.

**The worker certification program was established and developed by the Department of Labor. A labor certification is a "determination that sufficient qualified workers are not available in the area of the United States to which the alien is destined to perform the work in which he will engage, and that his employment will not adversely affect the wages and working conditions of residents of this country similarly employed." (U.S. Immigration and Naturalization Service, *Annual Report*, 1974, p. 7.)

In the meantime, two of Eulalia's sons, Rogelio and Eugenio, aged twenty-six and twenty-two respectively, had followed their sisters with the hope of improving their economic status. In their country, Rogelio had worked as a printer and Eugenio as a plumber. Upon arrival in Washington they learned that unskilled food service and cleaning jobs were more readily available to them than specialized trades. As a consequence, they have continued to work in unskilled jobs up to the present. Eugenio married a woman from his own country, and they have an infant son. A child of his by a previous marriage remains in his country of origin under the care of his former spouse, from whom he separated because of reports of her unfaithfulness.

Eulalia and Mauricio, her sixteen year old son, were the last members of the family to come to the United States. After her first visit "to see what life was like in Washington," she had returned to her country but had decided that she would accept the invitation of her children to immigrate.

When Eulalia first came to visit she stayed with Helena. About this time, Eugenio married. Soon after Eulalia returned home to prepare for her permanent return to Washington, María, her husband, and their children moved to a suburban townhouse complex whose tenants were working-class families and students. Helena stayed in Washington until she was joined by Eulalia and Mauricio. She then rented an apartment in the same complex where María lived and was joined by Eugenio, the married brother and his pregnant wife, who stayed with them until a few months after the birth of the baby. He and his family then moved to another apartment in the same area. After Helena returned on a resident visa, with her mother and son, they came to the same apartment complex. The three now live there with Mauricio.

All of the adults in María's and Helena's households work at some distance from their homes. Eulalia worked for a short time. When she found her job too strenuous, she decided to assume responsibility for the supervision of her grandchildren when they came home from school.

Thus the process of entry of the Mora family -- Eulalia, her five children, and two grandchildren -- took place over a period of seven years. The living conditions of the Mora family seven years after entry contrasted in several noticeable ways with the rooms in live-in domestic jobs in which María and Helena had started. The expansion and fission of the households were shaped by life cycle events and their experiences in Washington. The selection of places to live in the city and the suburbs was made so as to facilitate and support the bonds of reciprocity. While it was not possible to house the whole Mora family within a single apartment, they lived so close together that kinship ties were actively supported.

This glimpse of a seven year period underscores the contributions of family members to the process of settlement. The series of steps which permitted the members of a household to enter, depart, and reestablish themselves in the United States had to be planned and orchestrated carefully. For example, Helena's dislike of her domestic job with a diplomatic family had to be measured against the cost and time required to secure resident status that would give her greater freedom in the selection of jobs.

Retrospective descriptions of entering and settling in Washington often brought to Eulalia memories of her lifelong struggle to raise her family. Her own mother had died when she was an infant, and her father did "best as he could" with his limited means. Under these circumstances, Eulalia went to school only a "couple of years." After her marriage she worked at home at various small businesses. When her husband left her, she started two home-based enterprises which gave her the income needed to raise her children. For twenty-two years prior to her decision to enter the United States, she ran a *comedor* (dining room) where she served meals three times a day. She also ran a small home-based store which sold "a little bit of everything." Her cooking earned her fame, and she herself believes that these experiences taught her a great deal about life. She noted, for example, that persons in business have to know about many things, "especially figures and numbers," so that "people don't cheat you." She had learned that in life "we all have problems of one kind or another." What matters, however, is that "we learn to face these problems" *(lo que hay que ver es como lo vamos afrontando)*. Eulalia believes that whether a person had good or bad luck in life, he must be willing to face each problem and to overcome it if he is to succeed.

PATTERNS OF ENTRY INTO THE UNITED STATES

Most of the immigrants in this study came to the United States to improve their general living conditions and their economic situation. Some immigrants were motivated by a desire to join relatives and friends; some had a commitment to work with a specific preselected employer.

A few came for miscellaneous reasons such as a lifelong ambition to come to this country, to undertake a course of study, or because a previous marriage or business had failed. In a number of cases, Latinos offered a combination of motives for entry.*

Washington was chosen as a first place of entry to the United States by most respondents (78.6 percent). Immigrants chose this particular city because they had relatives or friends in the area or because they had prearranged work agreements with employers. A few entered for miscellaneous other reasons. Mothers who were single or formerly married and had children twelve and under** were motivated to enter largely by a desire to improve their economic situation and to carve new opportunities for themselves and for their children. Their contact at entry was usually a sibling, a friend, or an employer.

The families of immigrants did not move as a group. The paths towards Washington were started by individual family members who would eventually bring relatives and close friends to the area. There was nothing particularly unusual about this "chain" migration of individual family members since the history of immigration to the United States is filled with such cases from all parts of the world. It is important to remember, however, as noted in Chapter 1 that the movement and settlement of the Latinos in this study were led largely by women. Moreover, most of these women had begun to establish their own households in Latin America prior to immigration, and thus they were separated from children, husbands, or other relatives for whom they had assumed some responsibility. They represent a growing proportion of Latinos who have received surprisingly limited attention in the literature about new immigrants or in recent major works about the people of Latin American heritage in the United States.

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*Sixty-six percent of the group came to the city because they had relatives or friends in the area; 23.7 percent came with work agreements; the remaining 10.0 percent came under miscellaneous conditions.

**At the time of this study, there were twenty-four mothers who were single or formerly married, with some children in the birth-12 age group. Sixteen entered after one or more children had been born in their country of origin. Six have had all their children born here, and two separated after settlement here.

Table 3-1 shows that women who came to this country in the year ended June 30, 1974 constituted well over half of the immigrants in the 20-39 age groups from the Central American countries, Panama, and Colombia. In these same age groups from Mexico, Peru, Ecuador, and the Dominican Republic, men formed a slightly higher proportion than women. It should be noted that these statistics include immigrants who led the migration of families and also those who entered as dependents. These

TABLE 3-1

WESTERN HEMISPHERE IMMIGRANTS ADMITTED TO THE UNITED STATES BY SELECTED COUNTRIES OF BIRTH, SEX, AND SELECTED AGE, YEAR ENDED JUNE 30, 1974

	20-29 years		30-39 years		40-49 years		50-59 years		
Country of Birth	Males	Females	Males	Females	Males	Females	Males	Females	Totals
Costa Rica	108	144	44	63	14	37	4	17	431
El Salvador	286	413	132	206	55	117	27	69	1305
Guatemala	297	372	102	131	27	59	16	57	1061
Honduras	145	262	79	117	28	64	11	42	748
Nicaragua	119	204	45	83	17	40	8	33	549
Panama	128	420	74	110	27	69	24	57	909
Colombia	859	1042	467	663	146	274	59	150	3660
Ecuador	631	716	407	394	66	175	66	152	2607
Peru	407	403	260	187	128	80	23	46	1534
Subtotals	2980	3976	1610	1954	508	915	238	623	12804
Mexico	10695	9144	4676	4479	1206	2252	769	1289	34510
Dominican Republic	1708	1807	1148	1012	534	694	306	518	7727
Subtotals	12403	10951	5824	5491	1740	2946	1075	1807	42237
Totals	15383	14927	7434	7445	2248	3861	1313	2430	55041

Source: U. S. Immigration and Naturalization Service, *Annual Report*, 1974, pp. 45-46.

figures represent persons who established immigration status for the year and do not include other groups of aliens such as students, temporary visitors (e.g., tourists), or undocumented workers.

Detailed examination of the history and sequence of migration followed by Latinos and their "significant others" in this study showed that in 68.9 percent of the cases a female had been the first of the family group to come to the United States. A good number of these women had initiated the move after they had already established conjugal relationships or had had children.* Such was the case also for the men. In other words, this was not a migration movement of single individuals who had not yet assumed parental roles. It was led by individuals -- both men and women -- many of whom had already entered the phase of parenthood.

The initiative exercised by women as they became the organizers and counsellors for other relatives who followed them to this country can be noted in the case of Magdalena Torres, one of the school parents in the study. At the time of the research, her household consisted of her husband and herself, two children, and a nephew. She worked as a beautician, although she had entered as a domestic with an American family for whom she had worked in her home country. Six months after her arrival, she brought one of her sisters to Washington, and a second sister followed a year later. Three adult nephews -- sons of her sisters -- entered next. She then succeeded in convincing her mother to come to visit them. She and the two sisters and their families settled in apartments located in the same block.

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*Although women tended to lead the migration movement, there are some differences in the proportions by male and female respondents. Among the men, 46.2 percent had a woman such as a wife, mother, or sister lead the migration of the group to the United States, and in 34.6 percent of the cases the man himself, a male relative, or friend had led it. Among women, in 74.7 percent of the cases, another woman or the respondent herself had led the entry to Washington.

In an analysis of trends in immigration and population growth in the United States, Conrad Taeuber notes that more than two-thirds of all immigrants to the country in the first decade of the Twentieth century were male; in the decade of the 1960's, the percentage dropped to 45. (Conrad Taeuber, "American Immigration and Population Growth," p. 8)

Magdalena and her husband were married in the United States, but they had known each other in the home country. Both had children by previous marriages. Her husband left his children by the first marriage with their maternal relatives, while Magdalena had brought her child to the United States after she had settled here. At the time of this research, she was involved in helping three other nephews come to Washington.

This tendency to join kin or friends who were already in Washington (noted also in the Mora family) points to the strong influence of these types of networks in Latino migration. This trend is reflected in statistics about the immigration of family members to the United

States for the year during which this research was conducted. In 1973, 63.3 percent of all Central Americans admitted to the United States listed their occupation as dependents, while 59.9 percent of all South Americans fell in this same category.[1]

Many of the immigrants who entered Washington under prearranged agreements (such as domestics) came in with the families directly from their country of origin. Magdalena, for instance, had met and worked for her employers in her Central American home city, and this family subsequently brought her with them to Washington.

In other cases, persons with friends in Washington, such as María Mora, had originally solicited their help to locate work. Usually careful prearrangements were made in order to ensure a successful move. Margarita Hernandez, a school parent, had consciously chosen to remain at her job as a highly skilled seamstress in her country for a period of five years because she knew that this type of labor would qualify her for entry to the United States. During this period, she was in active correspondence with a girlfriend who located employers willing to give her a work contract. Thus she came in with an approved resident visa, and after she was settled in her own apartment she brought her children to live with her. Her husband remained at home. Margarita used the move to Washington to separate from him because of longstanding incompatibility.

Some of the Latinos who were illegal aliens at the time of the study had originally entered the country with some time-limited permission, such as a student or a tourist visa. Others had crossed the border without any entry documents. Those whose visas had lapsed continued to search for work situations which would require their skills or for employers who would sponsor their entry as permanent residents.

Some of the men and women who had crossed the border without any papers had been caught by immigration officers and deported. Most of them had returned to the United States, and some had a history of repeated entries. They, like other respondents in the study, had active circles of kin and friends to assist and advise them.

The migration patterns of the illegal aliens were different in some ways from those of immigrants. Women who crossed the borders illegally did not usually bring young children with them, since this was considered too grave a risk. Subsequent to entry, such mothers brought their children to Washington only when they felt that their jobs and living situations were stable enough to permit it. The restrictions on immigration, however, have made it increasingly difficult for parents who feel unsettled in their designated visa categories to have their children join them.

For example, some mothers on student visas who had children in their countries of origin seriously considered staying in Washington after their visas expired. However, separation from children was difficult for some students, particularly since they could not visit their children at home without the possibility of encountering difficulties in reentering the United States. Moreover, student visas were not easy to obtain.

There was another path, but it was difficult for people with limited means. Relatives in the home country, such as a respondent's mother, could bring a young child to visit with the parent who was a student. However, U. S. consular officers in the countries of origin, fearing that such children would be left with their parents in the United States, in some cases, required the posting of a bond of $1,000 at a minimum, to ensure that the child would be returned to the country of origin.* Officials realized that the child left with parents in the United States would offer additional incentive for parents to remain in the country.

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*For statutory background of this practice, consult Public Law 414, June 27, 1952, Immigration and Nationality Act as amended. Section 214(a): "The admission to the United States of any alien as a nonimmigrant shall be for such time and under such conditions as the Attorney General may by regulations prescribe, including when he deems necessary the giving of a bond with sufficient surety in such sum and containing such conditions as the Attorney General shall prescribe, to insure that at the expiration of such time or upon failure to maintain the status under which he was admitted, or to maintain any status subsequently acquired under Section 248, such alien will depart from the United States."

MARITAL STATUS, FAMILY SIZE AND PATTERNS OF CHILD CARE

Marital Status

As Table 3-2 shows, at the time of this study 48.5 percent of the immigrants were married.* A total of 23.8 percent were divorced, widowed, or separated, and 16.5 percent were single mothers. The only male in the single-parent category was divorced.**

Immigrants who had never married and never had children constituted 11.3 percent of the total group. Most of these people had high educational attainments, in comparison to the total study population. The men had finished high school or they had partially completed university studies, while the women had trained for careers as teachers or in specialized secretarial fields. Most of these men were from middle-class families, or they were the only child of a single mother. The women were only children or the only sister among high-achieving brothers.

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*For purposes of this research, the married category was defined as including persons who had married in a civil ceremony or in the church, and those who had lived in enduring common-law relationships.

**Towards the end of this research, this divorced male remarried.

While data about remarriages were not gathered systematically, I knew of cases in which remarriage had taken place in Washington. The new spouses were usually other Latinos. Separation was often due either to the breaking off of a common-law relationship or to the reported or confirmed unfaithfulness of a spouse.

TABLE 3-2

MARITAL STATUS OF IMMIGRANTS

Attribute	Number n=97	Percent
Single, never had children	11	11.3
Single parents, never married	16	16.5
Married	47	48.5
Widowed	5	5.2
Separated	13	13.4
Divorced	5	5.2

Family Size

The mean size of the community families was 2.8 children (live children), while the mean size of the school parent group was 3.3 children. Of the total group of parents with children, most (89.5 percent) had children, seventeen and under, though in a few cases (8.2 percent) all of the children were over eighteen. Childless marriages constituted only 2.4 percent of the total.

Patterns of Child Care

Findings about the place of residence of children showed that 43.0 percent of all parents had some children remaining in their country of origin.* Community and school parent groups differed as to the proportions of children seventeen and under still left in Latin America. Whereas 50.0 percent of the community parents had some of their children seventeen and under still living in their places of origin, only 10.2 percent of the school parents were in these circumstances. These contrasts appear to be associated with the length of residence of the immigrants in the United States. As noted in Chapter 1, slightly over half of the school parents (53.1 percent) had been in Washington for six years or more, whereas only 16.7 percent of the community group had been in the city for that length of time. Characteristically, community parents were in the early phases of settlement, trying to establish viable living situations, including the official approval of residence which would facilitate the entry of spouses and children.

Table 3-3 shows the location of children by specific age group and population. Almost half of the children seventeen and under in Washington as well as in the home

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*Fifteen respondents had all their children in their home country. Twenty had some children in Washington and some in their place of origin.

TABLE 3-3

LOCATION OF CHILDREN, BY AGE GROUP AND POPULATION*

	Washington, D. C.				Home Country			
	Community n=20**		School n=49		Community n=22		School n=12	
Age Group	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Birth to 6	7	25.00	29	20.14	13	19.40	1	5.00
7 to 12	3	10.71	61	42.36	22	32.84	4	20.00
13 to 17	10	35.71	30	20.83	10	14.93	4	20.00
18 and over	8	28.57	24	16.67	21	31.34	11	55.00
Unknown					1	1.49		
Totals	28	99.99	144	100.00	67	100.00	20	100.00

*Forty-nine respondents had all their children in Washington. Fifteen respondents had all their children in their home country. Twenty had some children in Washington and some in their place of origin. In three cases, respondents had children in Washington and elsewhere in the United States; in one case, the immigrant had children in the home country and elsewhere in the United States; in one case, the respondent had children in Washington, in the home country, and elsewhere in the United States. All children elsewhere in the United States were eighteen and over.

**The numbers of respondents totals more than the total of parents with children because some had children in Washington and in the home country.

country were in the phase of later childhood (seven to twelve). The remaining children were divided almost equally between the stages of early childhood and adolescence. The concentration of children in the late childhood phase was undoubtedly influenced by my selection of one group of respondents who had children at the elementary school level. It appeared to be associated also with the age structure and phases of the parenthood cycle of the immigrants themselves.

This table points to further contrasts between the community and school groups. There appears to be a relation between the location of children and the degree of settled residence in the United States. To test the independence of the categories of data appearing in Table 3-3 on children seventeen and under, Table 3-4 was constructed. Comparing the community parents with school parents and allowing for five degrees of freedom, a Chi-square value of 89.92 was obtained. At the .01 level of significance the null hypothesis that there is independence between location of children and degree of settled residence was rejected. There is clearly a relation between these two factors; the more settled the immigrants are in Washington, the greater number of their children are with them.

With regard to the location of children by the living situation of the immigrant parent, Table 3-5 shows

TABLE 3-4

X^2 TEST OF INDEPENDENCE: LOCATION OF CHILDREN SEVENTEEN AND UNDER BY POPULATION

	Community		School		
Age Group	Observed Number	Expected Number	Observed Number	Expected Number	Total
		Washington, D.C.			
Birth to 6	7	(12.1)	29	(23.9)	36
7-12	3	(21.4)	61	(42.6)	64
13-17	10	(13.4)	30	(26.6)	40
		Home Country			
Birth to 6	13	(4.7)	1	(9.3)	14
7-12	22	(8.7)	4	(17.3)	26
13-17	10	(4.7)	4	(9.3)	14
Total	65		129		194

$X^2 = 89.92$ df = 5 $p < .01$

TABLE 3-5

LOCATION OF CHILDREN BY AGE OF CHILD AND LIVING SITUATION OF IMMIGRANT PARENT*

	Child's Immigrant Mother with Spouse Elsewhere n=43		Child's Immigrant Father with Spouse Elsewhere n=4		Child's Parents Together in Washington n=36	
	LOCATION OF CHILD					
AGE GROUP						
	Washington n=36**	Home Country n=19	Washington -	Home Country n=4	Washington n=33	Home Country n=11
Birth to 6	12	6	---	3	24	5
7 to 12	18	12	---	6	46	8
13 to 17	21	10	---	2	19	2
18 and Over	24	25	---	1	8	6
Unknown				1		
TOTALS	75	53	---	13	97	21

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*Forty-nine respondents had all their children in Washington. Fifteen respondents had all their children in their home country. Twenty had some children in Washington and some in their place of origin. In three cases, respondents had children in Washington and elsewhere in the United States; in one case, the immigrant had children in the home country and elsewhere in the United States; in one case, the respondent had children in Washington, in the home country, and elsewhere in the United States. All children elsewhere in the United States were eighteen and over.

**The number of respondents totals more than the total of parents with children because some had children in Washington and in the home country.

that over half (61 percent) of the children in the home country were left by an immigrant mother who was not living with her spouse at the time of the study (due to death of spouse, separation associated with immigration, or permanent types of separation). Approximately one-fourth of the children in the home country (24 percent) had immigrant parents in a conjugal unit in Washington. A small group of children left behind (14 percent) had immigrant fathers who were without their spouses in Washington.

Given the age groupings of all children, I had special interest in the patterns of child care of children left behind. Table 3-6 shows these patterns by age group and population. As noted earlier, it was the usual pattern that the male immigrant who had led his family in the process of entry typically left young children with his wife or a former wife. These caretakers were almost always the biological mothers of the children. There were three exceptions to this pattern. In one case, the child was under the care of a maternal aunt; this was recognized as a temporary arrangement, until the child received approval for entry. Both of the child's parents and all of his siblings were in Washington.

In two cases, children were in the father's household, representing unusual circumstances, as compared to the patterns found in the study group as a whole. In one

TABLE 3-6

COMMUNITY AND SCHOOL SAMPLES: NUMBER OF CHILDREN IN HOME COUNTRY, BY AGE GROUP AND CARETAKER*

Age Group	Male Immigrants with Spouse Elsewhere	Female Immigrants with Spouse Elsewhere or Couple-Based Households					
Community	Child's Father's Kin	Child's Mother	Child's Maternal Grandmother	Child's Maternal Aunt	Child's Older Sister	Friend of Mother	Total No. of Children
Birth to 6	1	3	7	2	-	-	13
7 to 12	1	6	8	2	2	3	22
13 to 17	-	2	4	2	2	-	10
18 & over**	-	-	1	-	-	-	1
Totals	2	11	20	6	4	3	46
School							
Birth to 6	-	1	-	-	-	-	1
7 to 12	-	3	-	1	-	-	4
13 to 17	-	-	3	1	-	-	4
18 & over**	-	-	-	-	-	-	-
Totals	-	4	3	2	-	-	9

*Fifteen immigrants had all their children in their home country. Twenty had some children in Washington and some in their place of origin. In one case, the immigrant had children in the home country and elsewhere in the United States; in one case, the respondent had children in Washington, in the home country, and elsewhere in the United States. All children elsewhere in the United States were 18 and over.

**NOTE: There were twenty-one children aged 18 and over in the community group but only one had a caretaker. Most were married. There were eleven children eighteen and over in the school group but none had a caretaker.

case, the father had abandoned his wife (a respondent in this study) to remarry. He had taken their son, and the child had grown up under the care of the stepmother. In the second case, the child's mother had remarried and had acceded to the wish of her former mother-in-law and niece to leave her son by her first marriage with the former husband's kin.

The women immigrants and the couples with younger children left behind depended almost exclusively on the maternal grandmother for child care. Those with children under six who had been left behind included single and separated women, married women who were in the process of reorganizing their lives after their husbands had abandoned them, and those in which both parents of the child were in the United States.

The immigrant's mother, as caretaker, usually lived in the respondent's community of origin. Upon the mother's departure, a child moved to the maternal grandmother's household. This move often meant contact with a wider group of maternal kin than had been typical in his mother's household. Our data thus strongly suggest that the availability of support by their mothers had made it possible for these women to lead immigration. These data, as well as the patterns of child care found among male immigrants, suggest that the immigrant's separation from children in the early and late stages of childhood serves to solidify the child's kinship ties with the maternal line. The consequences of this pattern at other phases of the developmental cycle need to be studied in greater detail.

Table 3-6 further shows that, although there were not too many adolescents in the home country, this was a stage when the caretaking role began to shift to a wider network of kin, notably respondent's married daughters or the female immigrant's sister. The only caretaker who was not a relative was the friend of a widow who had lifelong contacts with the family.

Immigrant parents sent regular remittances home for the care of their children. The amount fluctuated according to the immigrant's type of work and income but ranged from a low of $10 to a top amount of $40 a month per household (not per child). I visited some of the homes with children of immigrants in Colombia and El Salvador. The households of Esperanza Lopez and Prudencia Sanchez, parents of illegal aliens in Washington, exemplified contrasts in child care patterns, influenced in part by the ages of the children left at home, by socioeconomic status, and by views about the meaning of migration.

Esperanza Lopez and her husband lived by themselves but were caring for their daughter's three year old child. Their daughter and her husband had left for Washington a year after the birth of this first child. Esperanza had hired a young maid to care for and play with the youngster while she and her husband tended to their business enterprises in town. Esperanza and her husband said that they hoped that their daughter would find some way to take this child to the States or, if not, that the daughter and husband would return to their home town.

Prudencia Sanchez lived with her husband, one unmarried son, and eight children seventeen and under who belonged to three of her children who had gone to work in Washington. During our visits she expressed some concern about her ability to cope with recurrent intestinal problems and the signs of weakness *(debilidad)* found among some of the children. She also discussed her own long-standing problem with her nerves. Her hopes were that, as the children got older, they would join their parents in Washington. As a matter of fact, the year following my visit to this home, the oldest child (an eighteen year old girl) and her new husband did come to Washington, but as illegal aliens.

The patterns of caretaking of working immigrants with children in the United States were associated with the age of the child. Infants and preschoolers were generally cared for by a relative, a paid adult baby sitter, or a nursery school. Among parents who worked in both day and evening shifts, some elementary school age children were left on their own during the early part of the evenings.

The presence of young schoolgirls in a household was a help to working parents. These girls were taught to assume household responsibilities, in some cases at earlier ages than would have been their experience in their country of origin.

For example, when I asked Rosa and Ana Ramos (twelve and nine years old, respectively) what they planned to do for the summer, they told me that they would not go to summer school, but "we will take care of the house -- one washes the dishes, the other vacuums. We will take care of Isabelita, our young sister." Both of their parents worked, and the older brothers who were high school students also worked part time.

In the Ibañez family, Nicanor, the father, came home from his office dressed in a suit and tie. Since he had an evening job cleaning buildings, he changed to jeans and ate his dinner, all in half an hour. The mother, Flora, who worked part time, saw an advantage to life in the United States because her children had learned greater independence. Her eleven year old girl could now cook the rice and other staples and have these ready for daily dinner. In South America, Flora would have dressed and bathed the children and never left them to do things on their own as she was doing in Washington.

She had concerns, however, about the effects of this independence on girls during adolescence, as she disapproved of the sexual freedom allowed in the United States.

HOUSEHOLD COMPOSITION

Data about marital status, children's residence, and their care, offered a basis for understanding the ways in which Latinos established their households in the host society. The descriptions of the composition of households which follow were considered to be of central importance to this research, since many major decisions about the processes of settlement in the host society and the management of crises and problems of health were made within such domestic units.

The households of immigrants were flexible units which expanded and contracted in accordance with the stages of entry and settlement and the transitions of the life cycle. Eulalia's family offered evidence of these patterns, as she and her children described their experiences in the establishment of their household through the period of seven years.

In general, as the immigrants achieved a measure of economic stability in the city, they became mobile, following paths similar to those of the established residents of Washington. Poor immigrants changed residence within the city rooming-houses and apartment buildings which no longer housed the middle class or affluent, or they moved to the fringe zones in the suburbs where rents were still low and public transportation was readily available. Those who had greater economic success were able to buy houses in the more remote suburbs of the metropolitan area and purchase cars. For them, the central city would remain a place of employment and a reminder of the first stages of their entry to Washington.

In a study of the place of residence of all respondents one year after the original research contact, I found that 40.2 percent of all respondents were at the same address, while 50.5 percent had moved elsewhere; data were unknown for 9.3 percent of the cases. There were marked contrasts in the patterns of mobility. Almost all of the parochial school families who had moved had gone to the suburbs. Parents from the public school had moved within the same school district. It appeared that the mobility of parochial school families was associated with higher income and a strong identification with patterns followed by their North American neighbors. Latinos from the community sample had moved within the city or to the countries of origin; some of the community sample who had been deported because of their illegal alien status returned to Washington within the year of departure.

For each family in the study, there were intersecting forces which shaped their households. Relatives arrived over a span of years; the phases of the life cycle called for readaptation and change among persons of all ages; residential mobility in Washington, a frequently found characteristic, created realignments of kin. The patterns of household organization in such changing circumstances were of special interest for theoretical reasons and in connection with my interest in the implication of the findings for the fields of health and mental health.

Although there is a small but growing body of literature about the structure of households of the Latino urban family in the United States,[2] questions as to the separation of spouses or of children seventeen and under due to migration have received limited attention. The perspectives of migrating women, which this study presents, have been neglected.

Table 3-7 shows that single men and women, who had never married nor had children, did not live alone but in households with relatives, employers, unrelated families, or with colleagues in a convent or seminary. Most of the single men lived with mothers or siblings. The single women lived with unrelated persons such as landladies, employers, female friends, or in a convent.

TABLE 3-7

SINGLE PERSONS: HOUSEHOLD COMPOSITION
(N=11)

Household Composition	Number of Cases
Single women's households (n = 6)	
Ego (F) and	
Female friend	1
Landlady and her family	3
Employers and their children	1
Colleagues in convent	1
Single men's households (n = 5)	
Ego (M) and	
Two brothers and sister-in-law	2
Sister and mother	1
Mother	1
Colleagues in seminary	1

With regard to the households of immigrants who had some children seventeen and under with them, there were contrasts between married couples and the single parents. The most frequently found household among the former was that of the nuclear family composed of the respondent, spouse, and children (n = 21). There was also a group of couple-based households with children seventeen and under who had members of the extended family present, particularly siblings or parents on the wife's side (n = 12) (Table 3-8). The mean number of children in the nuclear families was 2.9 while couple-based households with extended kin had a mean of 3.0 children, but the age distribution of children did not differ in these two types of households.

Of the twenty-one households of single parents with children seventeen and under, only eight included no other persons. The remainder had relatives domiciled with them. Often these were collateral, such as an immigrant's sister, alone or with her family, or else members of ascending and descending generations, particularly parents or grandchildren (Table 3-9). The single mothers with children seventeen and under who lived alone tended to be older than those who had other relatives with them, and with one exception, all of their children were over ten. The mean number of children in these households was 2.0. This contrasts with the situation among those house-

TABLE 3-8

MARRIED IMMIGRANTS: HOUSEHOLD COMPOSITION
(N=47)

Household Composition	Number of Cases
Couples with some children 17 and under in the household n = 33	
Married women's households n = 19	
Ego (F) and	
Husband and children	10
Husband, children, brother, sister-in-law, nephews, and nieces	1
Husband, children, brother and mother	1
Husband, children, sister, nephews, and mother	1
Husband, children, and brothers-in-law	1
Husband, children, and sister	1
Husband, children, and mother-in-law	2
Husband, children, and adult nephew	1
Husband, children, and servants	1
Married men's households n = 14	
Ego (M) and	
Wife and children	11
Wife, children, sister, and mother	1
Wife, children, and mother-in-law	1
Wife, children, and daughter-in-law	1
Couples with none of the children 17 and under in residence n = 2	
Ego (F) and	
Husband	1
Ego (M) and	
Wife and brothers	1
Couples who were childless, or with all children over 18 and outside the household n = 3	
Ego (F) and	
Husband and mother (childless)	1
Husband (child over 18 married and in residence elsewhere)	1
Ego (M) and	
Wife (childless)	1
Married women waiting for husband (all children 17 and under, or all children over 18) n = 2	
Ego (F) and	
Children 17 and under	1
Children 18 and over and granddaughter	1
Married persons in special circumstances n = 3	
Ego (F) and	
Employers	1
Ego (M) and	
Mother	1
Brother, sister-in-law, nephew	1

TABLE 3-9

SINGLE PARENTS*: HOUSEHOLD COMPOSITION
(N=39)

Household Composition	Number of Cases
Mother with some children 17 and under in household n = 21	
Ego (F) and	
Children alone	8
Children, mother, and father	1
Children, mother, and niece	1
Children, and grandchild	1
Children, grandson, and female cousin	1
Children, and two grandchildren	1
Children, two sisters, nephew, niece and mother	1
Children, sister, nephew, and female cousin	1
Children, sister, and brother-in-law	1
Children, sister, brother-in-law, and niece	1
Children, brother, nephew, and mother	1
Children, and brother	1
Children, and female cousin	1
Children, female cousin, and male cousin	1
Parent with none of the children 17 and under in residence n = 5	
Ego (F) and	
(Alone)	1
Sister, brother, and female cousin	1
Two female cousins	1
Employers	1
Ego (M) and	
(Alone)	1
Mother with children over 18 only present n = 5	
Ego (F) and	
Children	3
Children, sister, brother-in-law and nephew	1
Children, grandchildren, and daughter-in-law	1
Mother with none of the children over 18 in residence n = 1	
Ego (F) and	
Brother, sister-in-law, nephews, and nieces	1
Mother with children 17 and under, with employers or friends n = 7	
Ego (F) and	
Children and employers	5
Children, brothers, and employers	1
Children and female friend	1

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*This category includes separated women, unmarried mothers, the divorced, and the widowed. The one man in the group was divorced.

holds with other relatives present, in which the median age of children was 9.5 years and the mean number of children was 2.5.

In this respect, the findings about parents with none of their children seventeen and under in residence are equally of interest. The couples and single parents included two divorced persons and three illegal aliens. One of the divorced respondents was a live-in maid who had an adolescent girl living in Washington in a boarding arrangement with friends. The divorced man in this group had married children eighteen and over in Washington and a small child under the care of his estranged wife.

As noted earlier, children seventeen and under who remained in their home countries were usually cared for by grandmothers, mothers left behind, or other maternal kin. Prudencia Sanchez, the woman I visited in Latin America, cared for eight grandchildren seventeen and under while her children established themselves in Washington. Two of these immigrants were separated temporarily from their spouses, who were searching for connections to enter the United States as illegal aliens. The third was a widow.

In studying these families in Washington and in visits with children and kin in the places of origin, I noted that most immigrants had found it extremely difficult to bring younger children to Washington. Almost all viewed separation from their children as a phase necessitated by dire poverty in the home communities. They conceived of reunion only with older children who could join them in the labor force. It was the older adolescents, therefore, who were encouraged to come to Washington in order to expand the total earnings for the family. During the course of the one-year follow-up of selected cases, I witnessed the process through which Prudencia's daughter in Washington used all her connections to help her oldest child (an eighteen year old daughter) and her new husband enter as illegal aliens. This was the case also with the two oldest children of a male respondent in this group.

The case of Josefa Domínguez, the only migrant worker in the study, pointed to differences between mother and daughter on career aspirations. Josefa wanted her oldest daughter, who was about to finish junior high school in South Texas, to come to help her by working in Washington. Her daughter did not want to do this. She asked for a second-hand typewriter instead, in order to practice typing at home. She also wanted a new dress for the graduation ceremony. Josefa finally decided to send her the money for the dress, and she borrowed funds to go to the graduation because her daughter had pleaded that she would be the only student without a parent at the ceremony. Josefa's own mother had died when she was young, and she remembered how sad it was "not to have a mother," especially on important occasions or during periods of crisis.

With regard to the households of the remaining respondents, Tables 3-8 and 3-9 show that there were two childless couples and a few parents who had only children eighteen and over. The single parents who had children only eighteen and over averaged fifty-three years of age, which was older than other single parents. The three cases classified under the heading "special circumstances" were respondents who were officially married but who (for reasons such as family dissension) were not cohabiting with their spouses at the time of this research. They did not have children with them.

The only parents who lived with unrelated persons were live-in maids, who had their children in these households, and one single mother with a child, who lived with a friend. The live-in homes usually provided the woman and her child with some independence in living arrangements, such as a separate apartment within a large house. I believe, however, that the arrangement could best be described as a "compound" household, since some aspects of authority and reciprocity were shared with the employers.

In summary, the case of Eulalia Mora and her family presented early in this chapter highlights the processes through which Latinos establish and reestablish themselves in the United States. In the remainder of the chapter, characteristics of the household structures of the total group were presented in detail.

The Mora family's case points to values which guide the respondents and their kin in the process of transnational migration and settlement. Eulalia's views emphasize that separation from the home is not the first major life hurdle a Latino immigrant faces. Respondents believe that life itself brings with it many problems. For the Latino, successful achievement consists, however, in a willingness to face each problem and to find ways to overcome it. The Mora case shows how careful planning, self-sacrifice, and hard work are core values which guide the Latino's ability to master difficult life problems.

Two types of households were typical of the Latino immigrants who were actively involved in the phase of child-rearing: the nuclear type, composed of father, mother, and children; and the extended type, usually composed of a mother alone, her children under eighteen, collateral relatives, and/or members of ascending or descending generations. During the settlement phase there was fluidity and flexibility in the households due to the particular patterns of their chain migration.

As households became reconstituted in Washington, sets of nuclear and extended households, composed of blood relatives and affines (relations by marriage) and connected by ties of propinquity, emerged as highly functional interconnected structures. The case of the Mora family suggests that the external bonds established by these sets of households contribute significantly to mutual assistance in such matters as job finding and child care. Through membership in these interrelated units, the immigrants appear to have heightened their potential to manage the problems of daily living and some of the stresses in their lives. The extended household is characteristic largely of the mothers who are alone with their children and other relatives. This group of mothers included those who had never married, the separated, the divorced, and the widowed -- a total of 60 percent of all the women in the study who had married or become mothers.

It should be noted that while some literature on the Latino family in the United States shows that extended kinship bonds are a source of emotional support and reciprocity, there is as yet little knowledge about the nature and impact of these dynamics among members of various kinds of single-parent households as well as among Latinos in nuclear families.[3] The present findings have highlighted selected aspects of the Latino domestic unit during the period of immigrant entry and settlement.

Data regarding the place of residence of children and the patterns of child care are of interest since almost half of all parents had some children still in their country of origin. Immigrant mothers who were without spouses tended to have a greater proportion of children left behind, as contrasted with couples or the men who lived without spouses. Clearly, the availability of maternal relatives, particularly the child's maternal grandmother, made it possible for all immigrants to resettle apart from children. The support of maternal kin is crucial for immigrants with children in the various age groupings under seventeen. There should be careful attention given to the impact of this support on the children as well as the immigrant parents. The problems of living of the caretakers themselves should not be overlooked.

When I visited Esperanza Lopez and Prudencia Sanchez, two of the grandmothers described above who were caretakers of the children of illegal aliens in Washington, I was instructed by their daughters in Washington to observe carefully the state of health of their absent children and to identify worries with which the caretakers at home needed assistance.

The questions which these visits raised for me were concerned with the impact on the caretakers of substitute parenting. The grandmothers, as caretakers of smaller children and youth, appeared to be carrying multiple role responsibilities which were not easy for them to assume. Esperanza, for example, was still grieving over the death of her mother, whom she had lost prior to my visit. Prudencia's responsibility for the eight children of her absent daughters and son in Washington, for an alcoholic husband, and for a son with this same problem, was recognized as the source of her continuous suffering from "nerves."

Although this analysis focused largely on the lives of Latinos in Washington, rather than on their children or the caretakers in the old country, attention should be given to the role and function of substitute parents in caring for the children of immigrants who remain in the places or origin. With an increasing trend for women in the child-rearing phase of life to become the leaders of international migration movements, consideration should be given to the impact of these moves both on the migrant who enters our country and on those left behind.

CHAPTER 4

PATTERNS OF WORK

Inasmuch as improved status was a central force motivating the move to the United States, work was a major concern of the immigrants. Jobs served to establish the first line of on-going contact with the host society and enabled the newcomers to compare their working conditions with those of the North Americans as well as with those of other Latinos. The work situation not only helped them to delineate the desirable and undesirable aspects of their identity with particular occupational groups but also offered opportunity for them to form notions about characteristics of North Americans which appealed to them or which they disliked. Work thus provided the Latinos with a microcosm of society in the United States.

INITIAL STAGES OF CAREERS IN THE UNITED STATES

The choice of occupations in Washington was determined, in part, by the kinds of arrangements and agreements entered upon prior to entry. Some Latinos had made prearranged agreements, while others had arrived without any prior job commitment. In all cases, nevertheless, adaptations required by their first jobs quickly brought the immigrants face to face with the realities of life in the new setting.

Most of the women in this study who had come with prearranged work agreements planned to do domestic work. Men with prearranged formal connections had come to take special courses in English or in technical subjects such as mechanics or computer work or to continue university studies.

Women in Prearranged Jobs

The domestic workers had usually come in with families for whom they had worked in their places of origin. This is not surprising in view of the fact that Washington is a city which attracts American families who have served abroad and many families of foreign diplomats and international civil servants. The household workers who entered under these circumstances characteristically went through periods of adjustment in the United States. Some would decide to remain with their original employers. Others would leave the families they came with in order to acquire greater independence and a higher income. The contrasting careers of Narcisa Duarte and Aleja Patiño are illustrative of the processes through which they had initially become household workers. Their first jobs in Washington provided a base for the directions which they subsequently chose.

Narcisa's career as a domestic had begun in South America when she left her small-town birthplace for a large city. She joined a sister who did day work for foreigners, among them Frenchmen and North Americans. Narcisa eventually became well-known as a cook, whose skills were praised by her employers and their guests. When one family of North Americans returned to Washington, they invited her to come up with them. They offered to help her to obtain her permanent resident visa. Since Narcisa had a cousin in Washington, she decided to accept this offer. She thought that the money she would earn would increase her support of her only son, who was under the care of another sister in their town of origin.

Upon arriving in Washington, however, she learned that life was difficult. The family paid her only $20 a month (in the mid-1950s), and she quickly discovered that this salary was far below American standards. She brought this to the attention of her employers, but they said that this was a fair amount, when computed on the basis of equivalent earnings in the local currency of her own country. There were other problems. She did not have a regular day off during the week, as was customary for live-in workers. Although she was allowed to go out at 3:00 p.m. one day a week, she had to be back in time to fix dinner.

One day a friend suggested that she file a complaint at her Embassy and "ask for the Ambassador," since this was a serious matter. Narcisa spoke with a well-known consular officer to whom she said, "Where I find the flag of my country I can get help." The case was taken to high-ranking Embassy officials, who noted that the family should have paid her "at least four times as much, even if she did not speak English." They called the family to inform them of Narcisa's grievances.

After this incident the atmosphere in the house was even less pleasant for her, so she found work with another American family and stayed with them until she saved $200 to go back to her country. There she went to the Ministry of Labor to file a complaint against her first employers in Washington. She was encouraged to file suit for back wages owed, as well as for money for uniforms, shoes, and other items to which she had a right under prevailing labor statutes. With money from the settlement she returned to the United States and started a new life as a day worker.

Aleja Patiño's circumstances of entry were quite different from Narcisa's.

Aleja was married and lived with her three children in South America. She had had an elementary school education, but she had not worked outside her home since marriage. In the late 1960s she decided to look into the possibility of emigrating to the United States because she felt that her husband's earnings were not adequate to support the children. She was also having difficulties with her husband who, in her opinion, had some form of mental illness. So she went to an employment agency which had advertised that its representatives could facilitate work contracts for domestic workers who wanted to go to the United States.

The details of the contract were worked out to her satisfaction. Although there were rumors that the agency was really a front for a white slave ring (*trata de blancas*) she went ahead with her plans because she trusted the man who ran the service in her city. During the course of her trip, she was frightened at the Miami airport when she was approached by a man who asked whether she was aware that she was really going to live in the home of a "maniac," who would abuse her. The stranger also asked whether she was married. After she asserted that she had a husband and children, the stranger left her.

Aleja arrived in Washington to work in the home of a health professional and his family. When I met her, she had left this home and was working by the day six days a week, dividing her time between two jobs. Day work gave her higher income and the independence which she needed to prepare for the arrival of her children. Since she appreciated the help which her original sponsors had given her, she arranged for a cousin to replace her.

Aleja subsequently brought her children to Washington. She worked hard to pay off the debts she had incurred for the cost of their travel as well as for the legal expenses connected with separation from her husband.

Prearranged Employment of Men

The men who entered the United States with formal prearrangements had done so through correspondence with language and technical schools or universities whose programs were known in Latin America. Some of these institutions ran regular advertisements in local newspapers. Arrangements for application and acceptance to these schools were handled through the mails rather than by personal liaison. Men who reached Washington through such arrangements tended to suffer initial disappointments. One of them was Oscar Rosales.

Oscar had written to a school which had arranged for his entry to study English and mechanical arts. The school had advertised that new students would be met at the airport and would be assisted with housing. He was neither met nor helped to settle. He considered himself lucky that he had a cousin who helped him during this stage. After a few months in the school, he decided that the matriculation and monthly fees were too high, and he withdrew to enter another academy. Eventually, he dropped out of the second school because he felt that they did not teach appropriately.

At the time of the study, he was critical of directors of language schools, particularly those who advertised that the only problem a Latino had was the handicap of not knowing English. He felt that some schools underplayed the problems experienced at work, or the conflicts with immigration requirements, stating that "papers could be fixed, but Latinos without English could not survive." Oscar's perception was that schools which promised help with visa papers had connections with immigration officials which could serve either to a student's benefit or to his detriment. Students who abandoned these schools and thus risked expiration of student visas had, he felt, good reason to be wary, lest former teachers or school administrators inform immigration agents. Oscar was particularly sensitive to this possibility because he had left school and thus had lost his visa. As a consequence, he had become an illegal alien.

Entry Without Prearranged Employment

The men and women who came without a specific job consciously engaged in what they retrospectively saw as a risk. They had decided to search for *buena suerte* (good luck), and they had depended on friends, relatives, and others for help in the location of work.

Modesta Ortiz, a laundry worker, Juan Cortés, a laborer, and Eugenia Suarez, a food service employee, were Latinos who had arrived without specific jobs. They entered, highly motivated by the enthusiasm of relatives and friends, only to face periods of uncertainty about finding employment. Thus they were ready to take the first job offered, even though they did not feel qualified for it. They hoped, however, that the first one would serve as a stepping stone toward their projections and aspirations about life in the United States.

Modesta Ortiz, the daughter of Prudencia Sanchez, recalled that a week after her arrival she had met a woman in her neighborhood who had asked if she could iron or clean a house; two such jobs had just become available. Modesta had no experience with ironing, but she believes that she got this job because the bosses, who were good to her, noticed her willingness to learn and to stay long hours whenever necessary.

Juan Cortés came to Washington with a friend who had convinced him that there was good money in cleaning the windows of tall buildings. He quit his job after two days, however, because he feared an accident. When he got home he spoke to the janitor in his apartment building who invited him to join him on the "line" (the state line between Washington and Maryland), at a spot where groups of Black men from Washington congregated every day in the hope of finding work with some construction crew. Juan found a crew leader who formed a group of six men to clean up the debris left when construction companies finished a building.

Eugenia Suarez, an elementary school teacher in her country of origin, had dreamed of earning enough money to buy a house there for her family. She was unmarried and enjoyed helping her parents and siblings. One day she met a girlfriend whose mother had left the country for work in Washington. The mother's reports of life there led the girls to decide to emigrate. Eugenia believes that she secured consular approval to visit Washington with a tourist visa rather rapidly because she had savings and a good credit rating.

Upon arrival she visited various city sites and then decided to remain beyond expiration of her tourist visa. She asked herself what kind of work she might perform. She could not be a teacher because of her deficiencies in English. She lived off her savings for a month. Then a friend suggested that there was a job available as a waitress in a club. This first work experience taught her that she would have to approach work in the United States ready to withstand the "suffering" associated with continuous orders from bosses and clients. To protect herself from men who made promises to secure a resident visa for her in exchange for sexual favors, she decided to adopt a special role. She chose that of a "poor" mother who had been forced to leave her children in her place of origin and had come to earn a living for them. She feels that this role has helped her to maintain distance and protect her honor, not an easy thing to do in Washington, a city where she has found that it is difficult for a Latina to maintain *pudor* (modesty, shame).

EDUCATIONAL AND OCCUPATIONAL LEVELS

Respondents were divided equally between those with some or full primary school* and those with some secondary school or even specialized training. However, there were marked contrasts in educational levels by sex. One-third of the women had some primary school education; a high proportion in this category had finished only two or three grades. Slightly over a third of the women had some high school education or had finished high school, and 4.2 percent had some university training. In contrast, half of the men had secondary education, while less than a third had only primary schooling. Most of the men had completed their education at this primary level, in contrast to the women, who tended not to have finished primary school at all. Nineteen percent of the men had some college or graduate level education (See Table 4-1).

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*The usual length of primary school in most Latin American countries is five or six grades.

TABLE 4-1

MALES AND FEMALES: EDUCATION, OCCUPATION, AND INCOME

(PERCENTAGE DISTRIBUTION)

Attribute	Percent Males (n=26)	 Females (n=71)
Educational Level		
None	3.9	2.8
Some primary	3.9	35.2
Complete primary	23.1	21.1
Some high school or technical	30.8	19.7
Complete high school	19.2	15.5
Some college	15.4	4.2
College graduate	3.9	-
Unknown	-	1.4
Occupational Level		
Not working	23.1	11.3
Unskilled	19.2	67.6
Semiskilled	26.9	9.9
Skilled	7.7	4.2
Clerical	11.5	4.2
Small business	7.7	2.8
Major professional	3.9	-
Annual Income		
Less than $1,999	7.7	11.3
$2,000 - $2,999	3.9	15.5
$3,000 - $3,999	11.5	28.2
$4,000 - $5,999	42.3	28.2
$6,000 - $9,999	19.2	7.0
Over $10,000	7.7	1.4
No income	7.7	4.2
Unknown	-	4.2

As with education, the occupational levels showed contrasts between men and women. Table 4-1 shows that men were concentrated in the semiskilled category (26.9 percent), unskilled (19.2 percent), and clerical groups (11.5 percent). In contrast, over two-thirds of the women 67.6 percent) were in the unskilled job category. Men in the "not working" category (23.1 percent) were in search of work or in some government-sponsored training program. Women who were not active in the labor force (11.3 percent) included those who did not work, those who had retired, and those in search of work.

The differences in occupational categories by sex are reflected in annual income. While over half of the women (55.0 percent) earned less than $4,000 a year, less than a fourth of the men (23.1 percent) were in this income bracket. Almost two-thirds of the men earned between $4,000 and $9,999, with a majority concentrated in the $4,000-$5,999 group. Two men and one woman were in the over-$10,000 income category. The woman was independently wealthy and a member of a diplomatic family.*

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*Annual income groups were computed for the respondents alone. The joint income of husband and wife, or contributions from other relatives in the household, were not included.

Types of Work and Comparisons with Former Occupations

At the time of the study, one-third of the women worked as maids. The rest of the women were in food service, janitorial service, and clerical jobs; some were seamstresses, and a few worked in skilled and semi-skilled positions. The men's jobs included work in food service industries, construction, and technical work such as automobile mechanics and television repair. A few men worked at miscellaneous occupations at the clerical, business, and professional levels. A few were students training for specialized skills which ranged from graduate work in counselling to special mechanical repair. In general, a greater proportion of men were in higher-ranking jobs than were the women (Table 4-1).

The contrasts in occupational levels between women and men reflected, in part, educational differences. Examination and comparison of the last jobs held in the country of origin with the positions occupied at the time of the study, showed more noticeable discrepancies for women than was the case with men. Women who had worked in their home country had occupied positions of higher status than in the United States, although they earned higher wages in Washington. Latinas were underemployed to a greater extent than men.

This held true among those who had occupied positions in their country as saleswomen, clerks, seamstresses, and owners and managers of businesses. Most of them changed from the tasks and responsibilities associated with clerical and semiskilled positions to less skilled work activities in Washington. It should be noted also that almost all the women who had not worked in their places of origin (18 percent of all the women) became unskilled workers in Washington. For a sizeable proportion of the Latinas in this study, therefore, entry and settlement in Washington represented a marked disjunction in work activities.

The experiences of Alicia Contreras and Eulalia Mora reflect characteristic ways in which these changes occurred.

Alicia, a single woman from Central America, had worked as a secretary, but in Washington she became a full-time domestic day worker who labored five days a week in five different homes. Although she did not like this type of work, her employers praised her highly, and she stayed with it. Alicia remembers that wnen she first arrived in this country she found herself too nervous to type rapidly. She had tremors in her hands which reminded her of the shakiness of her elderly father. She became increasingly worried about the eventual death and loss of her parents. Although she took special English courses to improve her speaking ability, they did not help her to overcome anxiety and nervousness. Settling for domestic work, she considered that she earned well in comparison to other friends. Out of her $340 monthly wages she sent $50 home for the support of her parents. She never told them what type of work she was doing. Only her sister, who is her special confidante, knows of her initial fears and her subsequent decision to labor as a household worker.

Eulalia Mora, like other women who managed their own businesses in the countries of origin, had first gone into unskilled work in the U.S. There was a marked contrast between the entrepreneurial skills achieved in running her dining room and store in Central America and the routine of running sheets through a steam press in a Washington laundry. Like other women who had been independent entrepreneurs in Latin America, she had quickly learned that her limited facility with English and the financial requirements for the establishment of business activities in Washington would not permit her to pursue such a line of work. During the course of this research, she abandoned her laundry job because she felt that the heat was not good for her health and devoted herself to the care of her grandchildren and the household. She missed going to work, but felt that she had to look after herself, since her health problems had become accentuated while she worked in the laundry.

Analysis of the work careers of Latino men showed that in the initial period in Washington, they had often labored in low-ranking jobs. However, there was greater upward occupational mobility among them than among women. Men had eventually shifted toward occupational activities which required skills similar to those last used in their country of origin. They often engaged in efforts to learn specialized aspects of certain categories of work such as trades or skilled technical jobs (*e.g.*, mechanics). The men who did not move into the same type of work as they had performed at home were illegal aliens who chose jobs in the places which they felt were least likely to be raided by the immigration authorities. Moreover, a few men who developed some physical incapacity in the United States moved into less arduous work which was not necessarily a higher-ranked occupational activity. Such situations are noted in excerpts from the life experiences of Pedro Moreno and José Ramos.

In his country of origin, Pedro had worked as a car mechanic. He went into this type of work in the Washington area and eventually broadened his skills to include trucks as well. At the time of the study, he felt ready to get back to automobile work, which was less strenuous than his new specialty with trucks.

José Ramos, a building cleaner, shifted to a less strenuous and lower-salaried job on medical advice. In his home country he had been a road engineer's assistant, assigned to mapping. Upon arrival in Washington he began to do construction work, which paid him well. He shifted to the janitorial line, cleaning buildings, because the physicians recommended that, due to what he called "fat in his heart," he needed to find work which required less strain. Cleaning buildings, however, did not pay as well as construction work. So he took on jobs for two separate organizations, a full-time job with a janitorial service and a job for a few hours on Sunday evenings. One of his physicians told him that this pace of work was not good for him either, but José and his wife found that extra work was necessary to supplement their earnings and to sustain them in the modest suburban home to which they had moved. In addition, he felt honored by the fact that he had been selected for the Sunday job, which entailed cleaning the office of a high-ranking executive of the organization -- a recognition he felt, of his trustworthiness and ability.

Time Devoted to Work

Most of the immigrants entered with the goal of working in order to attain higher levels of living for themselves and their families. They believed that parents ought to sacrifice themselves for their children.

Consequently, it is not surprising that 73.2 percent of the population held full-time jobs,* while 12.4 percent worked part-time or sporadically, leaving only 14.4 percent who did not work at all (Table 4-2). The latter included six who were in training programs or actively seeking work and eight others who were either retirees or housewives not in the labor force, one of whom -- the only one in the study -- was on public assistance. Table 4-2 on work status and total time at work illustrates the heavy investment in work by both men and women.

Of the full-time workers almost one-third not only held down a full-time job but "moonlighted" as well. With one exception, those who worked extra hours reported difficulties with English, some not knowing the language at all. The women were single parents with some of their children and other relatives in the household. Detailed examination showed that their annual income was in the

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*"Full-time work" is defined as the dedication of most of the work day to one occupational activity. This includes categories such as live-in domestic workers whose work sometimes entails a longer work day than the standard eight hours, or certain categories of food service occupations with a long day divided with breaks in the afternoon or at slack times between meals. "Part-time work" means regularly scheduled activity which is limited by the hours and salary. "Sporadic work" is unscheduled activity which depends on short-term demands, such as catering at parties during the social season. "Full-time and sporadic work" refers to persons who hold a full-time job and "on demand" week-end work. "Full-time and part-time work" refers to persons who hold a full-time job and regularly scheduled part-time work, such as domestics who work on Saturdays and Sundays or on their days off in addition to their five-day week.

TABLE 4-2

MALES AND FEMALES: BY WORK STATUS

(PERCENTAGE DISTRIBUTION)

Attribute	Percent	
	Males (n=26)	Females (n=71)
Work Status		
Working	76.9	88.7
In search of work	15.4	2.8
Does not work	7.7	8.5
Total Time At Work*		
Sporadic	3.9	4.2
Part-time	3.9	11.3
Full-time	46.2	52.1
Full-time and sporadic	7.7	1.4
Full-time and part-time	15.4	19.7
Two full-time positions	3.9	----
Not working	19.2	11.3
Work Status by Single or Several Jobs		
Yes, more than one job	26.9	29.6
One job only	50.0	59.2
Not working	23.1	11.3
Interest in Change of Occupation		
No information	----	5.6
Yes	50.0	60.6
No	26.9	22.5
Not working	23.1	11.3

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*For definitions see note on page

$3,000-$3,999 category. In contrast, the men were married, with working wives, and under heavy expenses in purchasing a home. The income of these men ranged from $4,000-$5,999 a year.

The patterns of work and household organization of the immigrants who worked more than full-time are illustrated in the cases of Estela Leon and the Ibañez and Ramos families. Estela was a single mother living with her three daughters (twenty-two, twenty, and fourteen years old respectively), a female cousin, and a grandson. Her two teenage sons remained under the care of an aunt in Central America. This aunt has also cared for the children of Estela's three sisters who have emigrated to Washington.

Estela's annual earnings fell in the $3,000-$3,999 range. She worked a Monday-Friday schedule, which started every day with the 6:00 a.m.-3:00 p.m. shift in a cafeteria. She came home and left again for the 6:00-10:00 p.m. shift in a janitorial service, where she cleaned buildings. Her twenty-two year old daughter worked as a waitress, supporting her year-old infant, and she helped with the expenses of the household. The twenty year old daughter was in a special training program to improve her clerical skills. The three women were saving money to bring the remaining two boys to Washington.

Among the married men with a heavy work load, the cases of the Ibañez family described in the previous chapter, and of José Ramos presented earlier, offer perspectives on their orientations and activities. Nicanor Ibañez was a white-collar office administrator who came home at 5:00 p.m. and had half an hour to change and to have dinner. He walked into the house in his suit and emerged with Levis and tennis shoes, which was the typical dress of workers in his janitorial service. It might be recalled that his wife worked part-time and his eleven year old daughter had assumed increased responsibilities with the preparation of dinner and management of the household. The Ibañez couple was working these extra hours to save money toward the purchase of a new home.

In the case of José Ramos, the man with the heart problem, the family had moved to a small home in the suburbs, and they had a number of financial obligations. Although he and his wife harbored some fears about the threats of heart attack (José remembers that his father had died of congestive heart failure at the age of thirty-five), they retained the belief that parents had to sacrifice themselves for the welfare of their children.

With the exception of one man, the part-time and sporadic workers were all women. Half of these women were married and living in nuclear households; the rest were single mothers whose households included other relatives. Most worked part time, on an average of three or four days a week. As domestics or in food services, they hoped to be able to extend their schedules to a full-time basis. The only skilled members of this group were a beautician and a high-fashion seamstress who also did interior decorating.

Hilda Molina was one of the single mothers who worked part time. She lived with her only son Roberto, aged nine, her sister, and her sister's husband. Hilda was a day worker in one household three days a week, and she did domestic work for a foreign embassy on the fourth day. She hoped to find another job to complete her week or to locate a store which needed seamstresses. She felt, however, that she would not be able to secure this desired position without greater fluency in English.

Working Conditions

The most important aspect of working conditions for the immigrants was their relations with supervisory personnel and or colleagues, in terms of *buen trato* (proper and good treatment) or *mal trato* (ill treatment, or lack of consideration).

Buen trato reflected the display of appropriate respect but, above all, the according of *dignidad* (dignity) to an employee. This is a core value of traditional

Latin American society. *Dignidad* gives worth and respect to persons, regardless of their status in the social hierarchy. This value was particularly meaningful in relation to the cultural background of immigrants and the types of jobs in which a good proportion of them worked in Washington. Most Latinos in this study came originally from working-class families in their countries of origin. Even prior to their entry into the United States, they were highly oriented to the type of enterprise and activity which would help them to achieve *dignidad* and status.

When the bonds based on *buen trato* had been established and intensified, employers or supervisors frequently became the trusted advisors of the immigrants and were sought out for solutions to various problems, depending on their particular phase of settlement. Some of the especially valued characteristics in relations between supervisors and immigrants are detailed below for three kinds of occupational endeavors: household work, food service industries, and janitorial services.

Among household employees, both live-in workers and day workers often described the mode of treatment by the women for whom they worked. Employers who had accorded *buen trato* to immigrants during the initial years in Washington not only had helped with translations and the preparation of documents but also had suggested resources to meet various problems, including personnel for needed health care. In addition, such household employers often gave valued information about other homes in which a family wanted hired help, thus assisting Latinas in their efforts to find jobs for relatives and friends.

Among day workers who were at different jobs on various days of the week, there was usually one favorite employer whose *buen trato* had led to the establishment of certain affective bonds, as in the case of Odila Ramos whose husband José has been mentioned above as holding both a full-time and a part-time job. Odila's favorite employer gave her some of the furnishings of their living room and dining room. After the birth of their youngest child, this same employer was selected to become godmother, thus enhancing the ties of reciprocity and affection with those of fictive kinship found in the *compadre* relationship (godparenthood).

Food service industries such as restaurants or cafeterias have a complex system of formal organization which includes workers, supervisory personnel, and patrons. These industries tend to have a formal as well as informal orientation of personnel. The "back room" dishwashers, glasswashers, cooks, assistant cooks, and salad makers are more efficient when waiters, bus boys, bus girls, and supervisors -- part of the "front" of the service -- show them due consideration. It was noted that conflicts were reduced quickly by supervisory personnel who relied on their personal influence as mediators to avoid delays in service.

The dynamics of conflict resolution in such settings was shown in the case of Francisco Lugo, who divided his kitchen-helper role between dishwashing and fetching supplies from the freezer. When he was accused of stealing a package of ribs from the freezer, he presented his case to a supervisor, who defended him and eventually located the missing package. When this supervisor was transferred, Francisco was highly distressed. This boss had become a confidant who understood the problems of illegal aliens and their need to keep away from places raided by the immigration agents. At his former supervisor's suggestion, Francisco eventually changed to another job.

A third example of *buen trato* by supervisors was found in janitorial service, a type of work which runs on various schedules and which has a range of jobs for men and women with differing work skills. Supervisors of evening or part-time work sometimes offered refuge to men and women who did not feel well enough to compete in day jobs. Such was the case of Alberto Rodríguez. Alberto had a serious case of rheumatoid arthritis but continued in janitorial work long after this had been discouraged by his physicians. He was able to do this because his supervisor had placed him in an "easy" dusting job. Moreover, the boss sometimes gave him rides to his physician, and on one occasion even gave Alberto $100 out of his own pocket to help defray extra medical expenses.

The cases just given indicate that employers or supervisors who extend *buen trato* to their employees are the representatives of the Washington society with whom the Latino is likely to have the most satisfactory contact. They are intermediaries through whom the immigrant learns about the host society. They act as guides in the early stages of settlement and as trusted advisors outside the immigrant's network of family and friends. As the protectors of illegal aliens and helpers of those in need, supervisors and employers have assisted these immigrants to adapt and to establish themselves in the complex urban environment of Washington.

When immigrants complained of what they considered *mal trato*, they often pointed to problems associated with social status, sex role relations, or contrasting cultural backgrounds as the source of negative experiences. Some Latinos felt forced to tolerate *mal trato* because they could find no alternative work options. *Mal trato* under these circumstances became a source of suffering (*sufrimiento*), which respondents associated with the plight of the poor. Some immigrants, however, had little tolerance for the lack of *buen trato* and left their jobs in search of more favorable working environments *(buen ambiente)*.

Eugenia Suarez, the single woman who had adopted the fictive role of a poor working mother who sacrificed herself for her children left in her home country, considered that the lack of respect towards her as a woman, which she had felt forced to tolerate, had contributed to her sensations of suffering. She wondered whether this had precipitated her *reumatis* (rheumatism).

Juan Cortés, the man who worked with the clean-up crew of six men, was laid off for three weeks during Christmas. Although he was supposed to get paid on the week before the holidays, he waited in vain for his boss to bring his December check to him. The boss appeared on the day after New Year's. Juan believed that his employer used the crew money to buy gifts for his family, whom he had visited in another region of the country.

Mercedes Lopez, Oscar's wife, was less tolerant of *mal trato* at work than were Eugenia Suarez and Juan Cortés. One day she mentioned to me that she did not feel well because of the circumstances under which she had quit her job as a restaurant table girl. A new male supervisor had been assigned to the group of table girls who worked together. They didn't like him because he sat "drinking coffee" instead of helping them during the rush hour serving periods. The girls complained to the manager, who yelled at them, saying that if they did not like the situation, they were free to go and pointed in the direction of the door. Mercedes left the job that same day. She expressed regrets about this action because up to that point the manager had shown *buen trato* towards employees. Retrospectively she thought the issue was, perhaps, that Latinas worked too hard and, in contrast to Blacks in the city, who received praise for their efforts, the work of Latin Americans went unrecognized.

The work experiences of Eugenia, Juan, and Mercedes suggest that the combined strains in social relationships and the threat of limited economic benefits were basic reasons for entertaining possible changes of occupational activity. Juan and Mercedes added their perspectives about the influence of ethnic membership on the leverage required to secure jobs or to receive recognition for work. Employment settings were the one place where most Latinos had contact with white or Black North Americans, as fellow-workers and as supervisors or employers. Yet when there were problems, the Latinos expressed their conviction that they were the least favored and most powerless of the ethnic groups in the city. This finding calls for further investigation.

Work Aspirations

Since more than half of the respondents indicated that they wanted to change jobs or type of work (Table 4-2), I wondered what these aspirations meant and what implications this finding had for understanding the career paths of immigrants.

The women who hoped to move eventually to skilled occupations such as beautician, licensed practical nurse, seamstress, or clerk had actually performed these types of work in their countries of origin. Upon migration to the United States, they had begun to work in less skilled jobs such as domestics or in food services. Their aspirations thus reflected a desire to leave their state of underemployment and to return to the type of work which they had done previously.

Women who wanted changes or promotions within the same work organization that employed them included most of those who had managed their own small businesses in their places of origin. Typically, the sought-after promotions reflected interest in moving from "back room" or low-ranking positions such as dishwashers and bus girls, to higher-status activities, such as salad girls or waitresses. These aspirations suggested that the entrepreneurial women who had advanced in their small business enterprises in Latin America found no comparable niches in the United States. This interpretation needs to be tempered, however, by noting their lack of fluency in English. Most of them did not feel that they spoke English well enough for the contact with clients required in a business.

The women who were not actively engaged in efforts to change jobs were those in live-in work, as well as those in the highest-ranked occupations such as saleswoman, office clerk, teacher, and assistant librarian, among others. Of all the women in the study, the live-in domestics appeared to have the least optimism regarding their ability to change their general way of life. They felt ill-prepared for any other type of work. Their life histories showed that most had lost one or both of their parents while they were small children and that they had started work as live-in domestics in the home country by the time that they were fifteen or sixteen years old.[1]

Most of the men who wanted to change occupations wished for careers as mechanics or jobs in special crafts such as radio and x-ray technician or draftsmen. Those who aspired for positions as mechanics had worked in this specialty before, or they had friends or relatives in these occupations. Men who sought unionized building and construction work were conscious of the benefits associated with organized labor. As in the case of some of the women, men in low-ranking work such as bus boy aspired to higher-ranking positions within the same organization, such as waiter. The highest-salaried respondent of the study, an owner of an electrical goods store, had diverse interests to which he aspired, including expanding his knowledge of political science.

Men and women who labored in unskilled work, in particular, were aware that jobs which some have classified as "obsolescent" (*e.g.*, domestic work), or "dirty work" (*e.g.*, certain food services or janitorial positions),[2] received limited prestige and fringe benefits. Their aspirations for change were based on assessment of realities that they had learned quickly in the new setting. Narcisa Duarte, the immigrant who had spent one of the longest periods of residence in Washington, could look back to the time of her entry in the 1950s when the ideals of increased support for her son at home had been shattered by realization of the unfair wages which her first live-in employers had paid her. With the assistance of various officials, she was able to bring pressure on this family and thus better her position.

Juan Cortés, one of the more recent arrivals to Washington, had quickly assessed what he considered as the dangerous aspects of a job washing the windows of tall buildings. The risks were not worth the income to him, and so he moved to the job of laborer in a clean-up crew. The uncertainties of this job strengthened his aspirations to find regular construction work, preferably a job protected by union membership. During the course of my study, he wondered increasingly whether a Latino such as himself, with limited education and fluency in English, could ever be hired in such jobs.

This issue of the gaps between a Latino's desired goals and aspirations and the realities of his life was a theme of special interest to me in the study of cultural and behavioral dimensions manifested in their health and mental health, as presented in the following chapters.

CHAPTER 5

SYMPTOMS OF ILLNESS AND CROSS CULTURAL COMMUNICATION

Good health is highly valued by the Latino immigrants. The typical phrase *vale más la salud que el tesoro* (health is worth more than treasure) underscores the central place of this theme in their lives. Analysis of data about symptoms of illness, patterns of help-seeking, and the world of treatment offers a basis for identifying social and cultural forces which shape their world. Findings relating to health and illness are of basic importance for those who wish to understand the nature of the Latino cultural system, since health and illness are central to the Latino outlook towards life.

Adams and Rubel, writing on sickness and social relations in Middle America, indicate that although public health efforts have begun to bring conditions of illness under control in this area, a major problem still remains. There is a need to explore ways in which people interpret symptoms in relation to scientifically recognized etiologies and syndromes.[1] Linkages between popular beliefs and practices and the scientific biomedical tradition should be understood. This issue is particularly important in the present study because the immigrants live and work in a major metropolitan area where health care constitutes a dominant concern of professionals and the public. Providers and consumers of medical care have interest in understanding how immigrants and minority groups communicate and manage illness as they reformulate beliefs and practices through contacts with representatives of popular and professional medicine.

The combined approaches of survey research and field observation made it possible for me to identify pervasive sets of cultural definitions and meanings which influenced ongoing concepts and management of illness in the contexts of home, work, and offices of physicians as well as in waiting rooms of outpatient clinics. As I worked in the field, however, the dynamics of cross-cultural communication demanded special consideration.

Field work calls for an understanding of denotative and connotative aspects of the language which patients use to describe symptoms. Spoken language has not only denotative aspects (what words stand for) but also connotative aspects (what words suggest).[2]

The connotative aspects of communication between respondents and caregivers were of great importance, since patients and professionals sometimes adopted postures of apparent self-confidence in their communication styles with each other without really understanding the different meanings attached to the language used. Under such circumstances, therefore, I paid special attention to cultural aspects of verbal and non-verbal communication in specific situations.

Immigrants quickly learned terms used by professional health workers such as *presión alta* (high blood pressure) and adopted them for use in their everyday discussion of health problems. Was *presión alta*, however, a term used by a forty-two-year-old woman to learn about her blood pressure, or did she really ask about the symptoms associated with the *edad crítica* (critical age of menopause)? I had to search for subtle meanings of language. How was I, as an anthropologist, to approach an understanding of the concept of *vista cansada* (tired eyesight) which did not appear to have the same connotation as in English?* On the one hand, I had to investigate how immigrants managed these particular disorders and many others, and how the complaints were interpreted by practitioners consulted for treatment.

On the other hand, I also needed to be sensitive to the specific language and assumptions on the part of providers of health care services. Professionals who deliver health care frequently assume that patients not only accept the professional's explanations about the nature of illness but that they also will comply with the doctor's advice. From the perspective of these caregivers, effective communication with patients is based on the assumption that, through proper use of a common language, patients understand and act upon the medical advice offered. Effective cross-cultural communication in medical care thus depends on personnel who speak the language of the patient *and* understand his ideas about the cause and cure of illness. But caregivers still face the challenge of communicating in such a way that they can secure action by patients.

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*Persons with *vista cansada* or *cansancio de la vista* (tired eyesight) usually describe such symptoms as burning sensation of the eyes, overheated eyesight, and frontal headaches. These symptoms are viewed as possible indicators of poor eyesight. Explanations are also frequently linked to excessive worry, fatigue, or overwork.

The present chapter focuses on the general symptoms and problems of illness reported by the total study population, types of practitioners, and special issues in cross-cultural communication between professionals and Latinos as seekers of medical services.

HEALTH PROBLEMS AND THE SELECTION OF PRACTITIONERS

At the time of the study 64.9 percent of the population reported some type of health problem. This total included 79.2 percent of the community group who were in active contact with health and social agencies and 51.0 percent of the school parents whose health status was unknown prior to the research (Table 5-1).

The most commonly reported complaints were aches of the joints and muscular discomforts, gynecological complaints, various gastrointestinal disorders, and nervous stresses. In addition to these categories, frequently recurring illnesses included headaches, respiratory problems, and complaints associated with the circulation of the blood and the heart.* The men and women who had no specific health complaints presented, nevertheless, certain recurrent symptoms. Women reported headaches to a greater extent than men, while men described recurrent gastrointestinal ailments more often than women.

TABLE 5-1

COMMUNITY AND SCHOOL GROUPS, BY PRESENCE OR ABSENCE OF HEALTH PROBLEMS

(PERCENTAGE DISTRIBUTIONS)

Respondent Group	Yes, Health Problem	No Health Problem
Total persons (n=97)	64.9	35.1
Community Group (n=48)	79.2	20.8
School Group (n=49)	51.0	49.0

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*To compare these reports of illness with data about initial medical diagnoses in a medical care setting which serves Latinos, analysis was made of the initial diagnoses or impressions of new patients who had sought care from the clinic during the six-month period prior to the initiation of the present study. The most frequently found categories were: Gastrointestinal problems, musculoskeletal difficulties, gynecological problems, genitourinary disorders, diseases of the skin, and psychological stress. Headaches and respiratory problems were also found with frequency.

Comparisons of health status reports by women and men showed that a considerably greater proportion of women (71.8 percent) than men (46.2 percent) felt that they had health problems. One aspect of interest was that, of the women with reported health problems, 88 percent were still working. Of the men in this same category, 58 percent were working and 33 percent were in search of work. It was my observation that even the immigrants with acute episodes of chronic illness tried to stay at work as long as possible. Workers in unskilled and semiskilled jobs in particular frequently had no sick leave benefits. Days off for illness and for medical consultation thus meant the loss of earnings that were already low.

The type of practitioners consulted for symptoms of illness was associated with the nature of a health problem. Table 5-2 shows that common gastrointestinal and respiratory symptoms, headaches, and problems attributed to the hot/cold syndrome were generally treated by the respondent himself, his kin and/or friends and employers. Symptoms linked with chronic muscular aches including arthritis, nerves, and skin problems tended to be treated both by professional practitioners and in the home. Gynecological problems, certain digestive disorders such as persistent "burning in the upper portion of the stomach," and complaints identified as involving the heart were almost always taken to physicians.

TABLE 5-2

CONSULTANTS AND PRACTITIONERS USED FOR VARIOUS TYPES OF HEALTH PROBLEMS

Types of health problems	Self/ Family	Other (*e.g.*, Friend, Employer)	Private Physician	Outpatient Clinic or Other Medical Facility
Gastrointestinal complaints	25	3	2	3
Respiratory symptoms	15	3	6	1
Recurrent headaches	35	6	15	2
Hot/cold syndrome	13	3	5	2
Chronic muscular aches	20	2	17	2
Nerves, anger, related symptoms	13	2	15	2
Skin problems	9	2	15	1
Gynecological advice/problems	3	1	16	6
Special digestive disorders *e.g.*, burning sensation-stomach	4	1	13	1
Complaints of the heart	2	-	8	-

The network of persons used for consultation and treatment in the home usually included the family, friends, and employers. There was, in addition, an active exchange of information and consultation with kin left in the home country, and these relatives sometimes sought the advice of specialists there in order to help the sojourner in the United States. Private physicians were the most frequently used professional practitioners in Washington; immigrants made less use of health care personnel in public health settings.

The Latino's limited use of public health services is due in part to the limited availability of local government-sponsored resources for the management of the problems of adult medicine. In addition, the private physicians consulted by immigrants tended to refer respondents to outpatient clinics in private hospitals. It should be noted, therefore, that this limited use of public services does not mean that Latinos underutilize the resources of professional medicine. As in the case of the Mexican American community studied by Karno, Ross, and Caper in Los Angeles,[3] the Washington Latinos rely on private physicians for ambulatory medical care. These findings underscore the need for a better understanding of social and cultural factors which influence the Latino patient's relationship with private practitioners.

SELF-DIAGNOSIS AND CONSULTATION WITH SIGNIFICANT OTHERS

Immigrants who defined and managed illness on their own and without specialists from the professional world tended to depend, nevertheless, on trusted persons *(personas de confianza)* for advice about the identification and management of illness. *Personas de confianza*, such as kin, good friends, or employers, offered counsel about the nature of an illness as they saw it, the quality and cost of medical resources, and/or the type of treatment believed necessary.

Latinos with recurrent health problems such as frequent throat infections or muscular pains sought help from relatives and friends in Washington. Their network of consultants also included kin in Latin America. This pattern was not surprising in view of the fact that a number of immigrants had spouses, parents, or children still living in their place of origin. The communication of health problems across the miles was tempered by the desire "not to worry" a loved one. It was done, nevertheless, with the hope of securing the best advice from both worlds and particularly to fill perceived gaps in treatment which they experienced in the United States.

An aspect of special interest was that, while immigrants sought counsel for their health problems from relatives or specialists in their home countries, they also offered their own advice to relatives at home, particularly to their children, parents, and spouses. Men whose wives were still at home, for example, sought my advice about some of the health problems which their wives described to them in correspondence. Pictures of absent children often evoked diagnostic comments about their state of health, followed by decisions to recommend or to send medicines to them.

During my field work in Colombia and El Salvador I became an active link in the two-way system of advice-seeking and advice-giving, which I illustrate by citing two cases among many. In one instance, I met Prudencia Sanchez, the mother of two sisters and a brother who were living in Washington. She was taking care of their children, a total of eight youngsters. At the bequest of their respective parents, I brought them various kinds of vitamins from Washington.

In another town, I had a number of discussions with Pablo Suarez, the father of Eugenia Suarez, a thirty-year-old food service worker in Washington. He asked me to bring back to her various medicines for arthritis which had been recommended by a respected pharmacist in the home country. During the year prior to my visits to his home, Pablo had sent his daughter other medicines to try out and had offered extensive medical advice by correspondence.

He told me how, upon first learning of Eugenia's symptoms, he had consulted the pharmacist about the types of medicines which should be used for arthritis. Since Eugenia had a history of digestive disorders, Pablo had taken careful note of the pharmacist's classification of medicines which had mild or strong side effects on digestion.

Pablo had also sent her a special *manteca de culebra* preparation (snake oil or lard) which he considered the "best" ointment for joint pains. He did not buy it in a drugstore because he knows that viper-based products sold in pharmacies are "not authentic." He asked a friend from his home town to secure the oil of a recently killed viper. The friend also brought him *cebo de cabra* (goat grease), which was highly recommended for massaging the arm and leg joints. Pablo had put these ointments in plastic jars and sent them by airmail to Eugenia in Washington.

Eugenia took the medicines and massaged herself with the special ointments. She also tried various medicines prescribed at an outpatient clinic in Washington. In addition she tried a special herbal infusion suggested by a woman who acted "like a mother" to her in Washington. It was she who suggested that these teas would help Eugenia with the retention and balance of body liquids required to *mantenerse bien* (remain well) and to restore the proper volume of uric acid to her body. Herbs for the tea were found in the Washington countryside and the gardens of two well-known city hotels.

The case of Eugenia Suarez is of particular interest because it illustrates both advice-seeking and consultation patterns with pharmacists in the home country and with a "trusted person" in the United States. Pablo sought a pharmacist whom he respected for advice on the nature of his daughter's illness and for consultation about medicines. The purchase of drugs for Eugenia's arthritis was done after he had received explanations about their possible side effects and suggestions about the particular medicines which would best serve his daughter's illness. Pablo had definite opinions, nevertheless, about the limitations of a pharmacist's competence as he referred to the belief that "viper" oils sold at drugstores were fake.

As anthropological research extends to the Latin American towns and cities of origin of Latin American immigrants to the United States, special attention needs to be given to the role of intermediaries between health care systems and those who seek services. Pharmacists, for example, are readily accessible for consultation and advice, and they offer for sale medicines from the scientific and popular medical traditions. They are key persons in linking Latin Americans with professional medicine.

When I interviewed a respected Salvadorean pharmacist in the home area of some of the immigrants in this study, he offered the following list of disorders for which he was frequently consulted: parasites of many different kinds, trichonomas, malnutrition, *deshidratación* (dehydration), liver and digestive problems, colds and respiratory problems, allergies and fungi, nervous disorders, and malarial fevers. He preferred to refer clients with certain illnesses, such as tuberculosis, to a physician or a health department before he sold them any medicine.

The Latin American immigrants in this study did not usually find this type of consultative and prescriptive advice available from pharmacists in Washington who typically work behind glass partitions and have little or no communication with the public. Instead, the immigrants used relatives or friends as central figures in the diagnostic process. The woman who acted "like a mother" to Eugenia in Washington provided a theory about the balance and neutralization of body fluids which emphasized health maintenance. She was not a full-time herbalist, but she had identified local plants in Washington which were believed to have preventive and remedial properties. As an amateur herbalist, this woman extended her knowledge of the local flora to friends and relatives.

There were actually few full-time healers *(curanderos)* or herbalists known to the immigrants in Washington. A scarcity of traditional diagnosticians was found also by Ailinger in her study of a Latin American enclave in a suburb of Washington[4] and by Edgerton and others in Los Angeles.[5] This is of particular interest because the literature about Latin American popular medicine usually points to the strong influence of healers on diagnosis and management of illness. In the present study, continued reliance on Latino forms of treatment receives support from the household and persons such as Eugenia's motherly advisor, who draw on their specialized knowledge on a part-time basis or as it is needed. Immigrants who return periodically to their homes in Latin America can also exchange medical knowledge and practices and in this manner contribute to the multicultural character of Latino popular medicine.

CONSULTATION WITH PHYSICIANS

Most of the physicians consulted by respondents were in private practice or in the outpatient service of private hospitals. This is of interest in view of the fact that 65.4 percent of the men and 83.2 percent of the women earned annual incomes under $6,000 and only 14 percent were covered by any health insurance plan.* These findings may reflect preferences found in Washington as well as in their countries of origin, for the care offered by private practitioners as against that available in public health clinics or municipally supported medical programs.[6]

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*Two women had Medicare and three were eligible for Medicaid. At least four school children were Medicaid-eligible, but the exact numbers cannot be determined from the available data since the survey did not focus on this question among children.

Latinos who were illegal aliens used the same types of resources for their symptoms as did other immigrants. With the exception of a woman who had given birth in a city hospital, all of them used private physicians or hospitals. This information was pertinent in relation to public inquiries regarding the health problems of illegal aliens. At the hearings of the House Judiciary Committee on Illegal Aliens[7] concern was expressed about the perceived tendency of illegal aliens to avoid the use of needed health resources, due to fears that immigration authorities could apprehend them. The illegal aliens in this study did not differ from the rest of the study population in their definitions of health problems or patterns of seeking care.

A finding of special interest, though not unexpected, was the marked preference for private practitioners who speak Spanish. Respondents in this study commonly used twelve private physicians, and of these, ten were known to be of Latin American heritage or to have a working knowledge of Spanish. Since 72.2 percent of the respondents reported that they had only a fair ability to speak English or that they spoke no English at all, the importance of common language and an understanding of culture for the delivery of health services to this population is obvious. Nevertheless, many of the patients who were referred by these physicians to the outpatient clinics of private and public hospitals did not have the option of selecting hospital physicians or other caregivers who spoke Spanish. In analysis of the data on outpatient clinic referrals, special attention, therefore, was given to the dynamics of cross-cultural communication, particularly during the periods of initial entry to these systems.

PROBLEMS OF CROSS-CULTURAL COMMUNICATION

I accompanied immigrants to the six outpatient clinics that they used most frequently. Observations in waiting rooms and at intake entry points offered insights into the challenges and dilemmas of establishing effective cross-cultural communication. The waiting rooms were important for the study of initial contact with health care systems, since at intake much more time was spent in these areas than with diagnostic procedures or with the physician and staff. The case of Rosa Flores points to the importance of waiting periods as optimal opportunities for patients to gain perspectives from each other about how to present themselves and how to communicate with staff in these settings.

Rosa was sent for her first appointment at the medical clinic of a university hospital by a physician who hoped that she would be followed for control of hypertension. Her first morning in the waiting room was instructive. She and other Latin American patients exchanged medical knowledge and took cues from those already familiar with the facility as to ways of approaching health care personnel. The following excerpts were taken from my field notes.

Waiting period -- 9:a.m.-12:00 noon:

> Rosa and I met at 8:50 a.m. . . . There were two very pregnant Latin American women. Their husbands joined them and they laughingly said that this was the last of a group of six couples who had started in prenatal clinic together. We joined their conversation. Much of this involved subjects related to the birth and sex of infants. This included the influence of the moon and birth control pills on the timing of delivery and the sex of the unborn child.
>
> We observed a Latin American couple who came to register for the first time. The clerk noted that they did not speak English and asked the woman: "Are you pregnant?" The husband answered in halting English that they did not know. "Then why are you here?" asked the clerk. . . . One of the husbands in our group and a staff nurse went to help the couple register. The nurse told the clerk that the woman came to learn if she was indeed pregnant. Rosa later said that the nurse's Spanish was not "good" but she did make herself understood.
>
> A young girl near us read a volume entitled "Black Poetry" while an older Black woman read a worn-out book of the Psalms. A few older White women sat rather immobile and in silence. Two middle-aged Black women said, "This is the best clinic, but the attitude of the staff is terrible; we do them the service so that their students get trained but they don't care; the charts get lost when they are really at the bottom of the pile. Doctors and nurses take lunch breaks when they want and leave us waiting. They think we have nothing to do but sit and wait."
>
> A young man with a Panther insignia on his jacket got up to tell the information clerk that he was leaving. The clerk who called out patient names scolded him saying, "The doctor who discharged you wants you to have aftercare; we can't make you wait but you should wait for registration. Do you have another place for aftercare? It's your choice."

> As I translated these comments to Rosa she explained that it was just like this when she had worked at a clinic pharmacy in her country. She would urge aides there not to have people wait because some probably felt as if they were about to die. She would tell the staff, "Hurry up, count the pills and put the labels on." Staff would sometimes joke with her that if they moved "too rapidly," they would have to sit and wait, and the patients would think that they had nothing to do.

In the waiting rooms, new patients developed perspectives about the system from those who had been in attendance over long periods of time. By the time that Rosa was called for her intake interview that morning she had decided that she would have to approach the staff in this clinic in a manner like that she used with the colleagues with whom she had worked at the pharmacy clinic in her country.

As I accompanied various Latinos to other outpatient services, I took careful note of the degree of sensitivity to cross-cultural communication which was shown. The hospital to which Josefa Domínguez was referred for her swollen jaw was of interest because of its concern for Spanish-speaking patients. Not only were there guiding signs in Spanish and English, but a number of staff in this setting also made conscious efforts to overcome the linguistic barriers. Some of the clinics had workers with Spanish-speaking ability who did the initial screenings. These staff members, in turn, located Spanish-speaking physicians and nurses for those Latinos who spoke little or no English.

Some problems emerged, however, when it was assumed that similarity of language between practitioners and patients was the only critical factor required to assure effective identification of symptoms and compliance with medical advice. The experience of Josefa Domínguez, for example, suggested that a shared language was but one of the elements essential to communication between practitioner and patient. Serious misunderstandings could result from factors associated with differences in social status, or from differing patient and physician concepts about the introduction of change in health beliefs and practices.

Josefa was initially presented with what seemed to be ideal conditions for effective communication of her ills. Her caregivers spoke Spanish, and she was not particularly concerned with how she should behave in relation to the health care staff. Yet, when her own diagnostic interpretation based on popular medicine was shunted aside, she adopted the polite demeanor customary in her country between subordinates and persons in authority. This interactive style was based on the assumption that the superior was the sole purveyor and controller of knowledge. The result was that on the one hand Josefa never indicated her lack of understanding of what she was told and, on the other hand, the health personnel assumed that she would abandon her belief system and follow the physician's concluding recommendations.

The intake worker, Miss Brown, overestimated her own ability to understand Spanish and neither she nor her coworkers realized her limitations. She had a tendency to confuse similar sounding words, such as *doméstica* and *Mexico*, which led to the recording of erroneous identifying information on the records. Although she had strong concern for the plight of the poor, she failed to understand the realities of life for one in Josefa's position, as indicated by the following dialogue.

Miss Brown: Are you a domestic *(Ud. es doméstica)?*

Josefa: Yes, I'm from Mexico *(Sí soy de Mexico).*

Miss Brown: I thought so! Does she work for you, Ma'am?

Anthropologist: No, she has been referred by Dr Smith. I'm a medical anthropologist.

Miss Brown: These poor people, I know them, Doctor. They don't know their rights; I'm a rebel myself; they don't learn English because someone always helps them. You shouldn't be with her. How many children do you have, Josefa?

Josefa: Four

Miss Brown: These poor people, such hard lives. I wish I were a doctor. I'm going to have her see Dr. Bolaños. He speaks Spanish.

Excerpts from subsequent visits:

Miss Brown: It looks as if she is Medicaid-eligible; I feel sorry for this poor woman; we think we have troubles. Listen, Josefa, what size dress do you wear? I may have clothes to fit you; I have gained weight.

Josefa: What are the numbers?

Miss Brown: Fourteen, sixteen, and eighteen.

Josefa: Sixteen.

Miss Brown: Oh, too bad. They won't fit. The ones I have are eighteen; I'm big, especially "up here" (pointing to her bust). What religion are you?

Josefa: Catholic.

Miss Brown: I'm Jewish.

After these interviews, Josefa had several questions and comments. She mentioned her usual embarrassment in asking for help. She remembered going to a welfare office where they had told her that she would receive help for her rent. She felt ashamed and did not return.

About the question of dress sizes, Josefa commented that she never brought dresses in stores but she had always had them made by seamstresses, who charged much less. Seamstresses had never given her a dress size. She asked what I thought her size was.

She wondered about the Jewish religion. She knew a little about other religions. She had met some *Alleluias* (Hallelujahs) who were the "ones who cry when they meet together to ask God to cure them," and the *Hijos de Jehová* (Jehovah's Witnesses) "who pray rather than cry" *(oran, no lloran)*.

Josefa's consultation with Dr. Bolaños, noted in the following excerpts and discussion, also raised questions and reflections on her part. The physician's assumptions that she would heed his efforts to change her beliefs about the nature of her disorder (or that she would follow his medical prescription) were not borne out, as the following exerpts from field notes on two clinic visits indicate.

First Visit:

Dr. Bolaños: What is the matter?

Josefa: *Aire*. (She offered explanations about her pain and her swollen jaw. After the examination, the following comments were heard.)

Dr. Bolaños: Señora, *aire* has nothing to do with your illness. What you have is a blocked salivary canal. Are there any *paperas* (mumps) in your house?

Josefa: No.

Dr. Bolaños: Well, I want you to begin with this medicine; if the swelling persists, we will have to operate.

Follow-up visit:

Josefa: I've not been well. I took three of the capsules you gave me; but my menstrual period was so heavy that I decided to discontinue taking them. I was worried because it had been two months since my last period. My stomach hasn't been too well.

Dr. Bolaños: No, the pills had nothing to do with your menstruation. If at all, you had diarrhea. . . . (Later) Here are some samples of an antibiotic and I want you to take this prescription to the pharmacy here in the hospital.

At the pharmacy:

Pharmacist: We don't have this medicine. (The pharmacist gave the prescription back to Josefa with no other comment).

Anthropologist: Well, what would you suggest that she should do?

Pharmacist: She should take it back to the doctor.

Anthropologist: What shall we tell the doctor that you have in stock?

Pharmacist: Tetracyclin; you know that doctors are supposed to consult the formulary before prescribing.

We went back to the doctor and he wrote out a new prescription.

Josefa also asked me some questions after her interviews with Dr. Bolaños. She wanted to know what *paperas* (mumps) were, and even after his explanation about the blocked salivary canal, she continued to wonder how it was that *aire* created the *Zzzzs* sensation that she had experienced. She hoped that she would not have an operation. She explained that she is used to "helping herself," although she knows a lot of women who use doctors for "every small pain."

During the interlude between these visits, she asked me what I knew about the menopause. She was forty-six, and some friends who had worked with her in migrant labor camps had told her that "it felt very badly." They had told her that the menstrual period came and went and that "afterwards women change." She wondered what would happen to her.

Josefa speculated about the reasons for her stomach trouble. She thought that it might have connections with her anger with a household employer who had given her a few days work but had failed to pay the full amount which she had first been promised. When Josefa claimed the full amount, the woman denied this promise of higher wages.

After these hospital visits, Josefa's swelling of the jaw disappeared, and she felt healthier in general. Interestingly, her summarizing conversation with me about successful treatment was focused on the course which she had followed at home rather than in the hospital. She indicated that to cure *anginas* (in this context, a swelling of the throat or neck area), the best treatment is a course of massages to loosen the swelling. She had asked her brother to massage her and attributed her improvement to this treatment. She believed that *anginas* were formed by heat which travelled from the lower to the upper parts of the body. To prevent them, a person should take baths in bathtubs, where the water covered the lower extremities up to the waist area. She had not taken these immersion baths recently, however, because the tub in her boarding house, a shared facility, was clogged.

This case serves to underscore the fact that the selection of practitioners who speak the language of the patient is only one aspect which leads to the achievement of effective cross-cultural communication. For members of similar cultural background or those who share a common language, there may still be communication problems because of differences in their perspectives as professionals and as patients.

Wilson indicates that of all the differences that may divide practitioner from patient within a given society, the subculture of the medical profession itself may be the most critical.[8] Friedson presents similar views in his analysis of the doctor-patient relationship. He states that the separate worlds of experience and reference of the layman and the professional worker are always in potential conflict with each other. Separateness seems to be inherent in the very situation of professional practice.

> The practitioner, looking from his vantage point, preserves his detachment by seeing the patient as a case to which he applies the general rules and categories learned during his protracted professional training. The client, being personally involved in what happens, feels obliged to try to judge and control what is happening to him. Since he does not have the same perspective as the practitioner, he must judge what is being done from other than a professional point of view. While both professional worker and client are theoretically in accord with the end of their relationship -- solving the client's problems -- the means by which this solution is to be accomplished and the definitions of the problem itself are sources of potential difference.[9]

The preparation of personnel for effective cross-cultural communication in medical care settings, therefore, should give attention to the subtle aspects of communication. In addition, health practitioners need knowledge and awareness of the sociocultural patterns which shape their own behavior as members of helping professions. Without this information, it may be difficult to understand how patients adapt their behavior to the expectations of the professional and paraprofessional. In Josefa's case, it is useful to examine a pattern through which she learns new information and meaning. This was commonly found among other immigrants in the study.

Adaptation to new life ways has meant that Josefa involves herself in continuous risk-taking. She enters new experiences such as a job or contact with new people with limited advance information about how she is expected to behave. She relies upon "on the spot" learning for guides and cues about the expected proper behavior and often adopts the overt behavioral forms expected of her and the use of key symbols. However, the adoption of vocabulary or behavioral forms does not guarantee full understanding of their meaning or of their implications for action. The specific conditions and demands of new situations may facilitate or retard the pace at which she and representatives of the host society achieve effective communication.

When she consulted the clinic, very early in her contacts she noted that in a patient role she could not engage in active discourse regarding her own concepts of illness, so she rapidly adopted a passive attitude. She answered politely, giving responses even to the questions which she did not understand. Although she did not know what mumps were, she gathered that Dr. Bolaños was asking her whether there was some threatening illness in her home. In the dialogue with Miss Brown she was asked for her dress size and chose a number "in the middle," which she felt was a safe choice. Neither Dr. Bolaños nor Miss Brown was aware of their problem in communication.

Dr. Bolaños spoke Spanish, but he was strongly committed to the scientific concepts of diagnosis and curing. Patients come to learn about their diagnosis from the physician, rather than to present their own interpretations about the nature of their troubles. He assumed that Josefa accepted his explanations about the reasons for her discomfort.

Josefa's subsequent discussion with me illustrates how, outside of the medical care contexts, a Latina conducts discourse about disease, its causes, implications, and treatment. It is in such interactive non-medical contexts, in particular, that the reformulation of ideas and practices about health and disease takes place. Some of the specific patterned beliefs and practices held by immigrants are illustrated in the following chapter, in discussion of four commonly found syndromes of illness.

CHAPTER 6

SYNDROMES OF ILLNESS AND POPULAR MEDICINE

Four frequently found syndromes illustrate ways in which cultural concepts manifest themselves specifically in symptoms of illness and their management: (1) disorders of the blood; (2) strong emotional experiences linked with the functioning of the heart; (3) disorders classified as obstructions of the gastrointestinal and genitourinary tracts; and (4) illnesses connected with the hot/cold theory of disease. These four categories were selected because they show a strong interconnection between the cultural, the physical, and the psychological that characterizes the management of health and illness by Latinos -- life-threatening syndromes, the common everyday illness, and diseases for which no ready cure appears to be available. This interconnection is particularly apparent in concepts of disease prevention.

DISORDERS OF THE BLOOD

Conditions related to strength and weakness of the body and mind are frequently associated in Latino popular medicine with disorders of the blood. Concerns with the strength, purity, or temperature of the blood include both the prevention and curing.

Blood, a vital force, has to be strong, pure, and in proper balance with other elements of the body. Early identification and intervention in the malfunctions of the blood leads to the maintenance of health as defined in physical, emotional, and spiritual terms. Weakness of the blood *(debilidad de la sangre)* is a major diagnostic indicator of emergent illness. Whether in an adult or a child, pale color, sallow skin, or loss of weight is associated with weak blood *(sometimes identified as anemia).* The "strength" of intellectual power and the proper regulation of conduct among children are considered to depend on qualities of the blood. School reports concerning learning or behavioral problems of children led respondents in this research to search first for a physical basis for these symptoms. Weakness of the blood was a major force held responsible for such problems.

Feelings of malaise and low spirits among adults *(decaimiento)* were likewise attributed to weak blood. Loss of interest in a job, diminished energy at home, or comments of friends about a person's loss of skin coloring led adults to search for practitioners who could prescribe proper medicines for a renewal and strengthening of the blood and, consequently, of their spirits.

A lowered blood temperature *(enfriamiento de la sangre)* was considered abnormal and conducive to dangerous illness.

Under life-threatening conditions in particular, respondents worried about the practice of drawing blood for analysis.

Narcisa Duarte, who was treated for cancer of the cervix, speculated whether her "tumor" had been caused by a cooling of the blood. When she was hospitalized for a diagnostic work-up she expressed strong anxiety about the many tubes of blood which were drawn for analysis. She had fears about the impact of this "loss of blood" on her prognosis, and she harbored doubts about the diagnostic value of these procedures. Hospital staff did not volunteer explanations about these blood tests or their results. She eventually resigned herself, believing that this hospital probably followed a practice of selling the blood of poor patients, which, in her opinion, was the common practice of hospitals in her country of origin.

Reasons frequently given for having weak blood were inadequate diet or irregular eating patterns and ingestion of blood-weakening foods such as acids. Anemia was associated with iron and dietary deficiencies or with excessive loss through menstrual flow. Although I did not obtain detailed data on nutrition practices, the dietary problems associated with weakness or malfunction appeared to have some associations with the volume of food. Children especially were expected to have hearty appetites.

Table 6-1 shows that iron, tonics, vitamins, and

TABLE 6-1

PROBLEMS OF THE BLOOD: TYPES OF TREATMENT

HOME-BASED TREATMENT		SCIENTIFIC SPECIALIST TREATMENT	
Home-Based Remedies/ Advice	Over-the-Counter Drugstore Medicines	Prescription Drugs	Prescriptive Advice and Treatment
NONE	*Vigorón*+ *Tónico Fersón*+ Laxatives Vitamins *Hemoglobina* Special iron supplements+	Medicine for anemia Pills, unknown name Liver extract Vitamin B12 Iron	Liver injections Blood analysis Blood drawn

+Medicine or remedy from home country.

laxatives were the most frequently used drugstore medicines for weaknesses of the blood. There were few physician-prescribed forms of treatment outside of liver extracts, miscellaneous medicines, and orders for blood work. On the basis of my observations, health care professionals did not usually pay much attention to symptoms of *decaimiento* reported by adults unless accompanied by other symptoms of illness.

IMPACT OF STRONG EMOTIONAL EXPERIENCES

Strong emotional experiences described with vocabulary from both popular and professional medicine, such as *palpitaciones* (palpitations) and *presión alta* (high blood pressure) were associated with disorders of the heart. These symptoms usually called for self-imposed discipline such as control of the self *(controlarse)* or avoidance of problems *(evitar los problemas).* The persistence of symptoms, however, led to heavy reliance on the physician.

The heart was seen as the center of psychological balance. Symptoms identified with this organ were usually separate from concerns about the condition of the blood. Terms associated with complaints of the heart often reflected anxiety, burdensome worries, intrusion of *aire* (air), or fatigue. Some respondents used the language of the media and professional health caregivers but still retained traditionally ascribed meanings. Those with medically confirmed hypertension wondered about the precise nature of this illness and continued to speculate about etiology and prevention long after they had resigned themselves to the need for periodic medical supervision.

The most frequently mentioned discomforts were those associated with irregularity of beat, particularly *palpitaciones* (palpitations), *picadas* (sharp or piercing pains), and *reflejos* (strong impulses or pulsations). Discussion about the onset of these symptoms was typically associated with nerves or anxiety, as in the case of Ana Gomez, who said that she felt *palpitaciones* and a backache particularly when she worried about her children who were still in her home country. Again, Jorge Santos recalled that the first time he experienced *palpitaciones* was upon arrival in the United States.

References to loss of breath *(irse la respiración)* or to intermittent sensations of choking *(siento como ahogo* -- I feel as if I were choking) were described by some respondents with a family history of hypertension and by others who were identified as hypertensives during the course of the present research. Alberto Perez, a thirty year old man with frequent digestive complaints noted that sometimes, while he ate, he felt sensations of a "loss of breath." He did not know if he should attribute this to his heart. His mother has *cardiaco* (cardiac trouble) for which a physician prescribed medicine, and his father suffered from *presión* *alta*. Alberto had never mentioned this family history to the doctors he consulted for his digestive problems, and the physicians had never taken his blood pressure.

The case of Rafaela Gil underscored the adaptations of traditional belief systems in a new life situation. For the past few years she had suffered from pains of the chest and of one shoulder. She had recent feelings of asphyxiation described as an inability to expel gases (as she pointed to her chest). She also had experienced periodic chills. Prior to her trip to the United States, she had similar sensations which she attributed to a *cólico de aire* (air colic). She now described these problems as *presión* due to her nerves, not to her heart. Interestingly, during the course of the study, she consulted a physician and learned that she had high blood pressure which required medical supervision.

An apparent increase in the use of the concept of *presión alta y baja* (high or low pressure) in the United States reflected a combination of the traditional usage of the term with notions adopted from professional medicine. Rosa Flores, the 31-year-old woman who had been under treatment for hypertension, had asked health professionals a number of questions about the nature and contributing causes of the problem. Her belief that it was hereditary had been confirmed recently by a physician to whom she had explained that her mother and an aunt suffered from *presión* *alta*, just as she did. To Rosa, *presión alta* meant that both she and her relatives were nervous and prone to *cóleras* (anger). To her knowledge, these relatives had never consulted physicians for *presión* or for their hearts.

Persons with medically diagnosed hypertension such as Rosa Flores and 50-year-old José Ramos, whose concerns are described below, incorporated explanations and terms taught by health professionals into their prior beliefs. Characteristically, however, these respondents continued to speculate about ways to treat or to eradicate this problem, so difficult to understand. The search for "better" facilities and more satisfying explanations appeared to carry with it a sense of dealing with fundamentally unknown and fearful aspects of the threat of heart attacks.

When Rosa Flores first asked a physician about her blood pressure, she wanted to know if she would have this problem for life. She wondered if this had some relationship to the *presión* experienced by her relatives. The physician explained about *escasa sangre* (inadequate blood flow) which had made Rosa wonder about the relationship of excessive menstrual flow to blood pressure. The physician had explained that blood pressure had two parts -- the "systolic" which was all right in her case, and the "diastolic" which was too high for a woman at age 31. Rosa felt that heredity was the most satisfactory explanation. She believed also that avoidance of upsetting situations *(contrariedades)* with her employers might improve her blood pressure; she remembered that her aunt had become "worse" when she experienced serious upsets in interpersonal relations.

José Ramos had been under control for high blood pressure for some four years. His wife had learned that the problem was due to the fact that the principal veins were clogged with fat *(las venas principales están tapadas con grasa)*. At times both of them believed that his problem was aggravated by the weather and by worries. He was under the supervision of an internist in private practice, who prescribed medicines and counselled him on proper diets and weight. Yet periodically his wife entertained various plans to prevent the possibility of the occurrence of a heart attack or to cure his illness. For example, a woman who helped them with their taxes had suggested that they take José to the "famous hospital in Baltimore" (Johns Hopkins) which had all kinds of specialists and was reputed to be the best of all hospitals. Alternatively, she wondered whether the couple might not invest their savings in a return trip home for physical examinations there. They thought that in their home country, "no one will deceive us," and they would learn "what really is the matter with José."

The listings in Table 6-2 suggest that there were relatively few home-based treatments used for this syndrome

TABLE 6-2

HEART PROBLEMS: TYPES OF TREATMENT

HOME-BASED TREATMENT		SCIENTIFIC SPECIALIST TREATMENT	
Home-Based Remedies Advice	Over-the-Counter Drugstore Medicines	Prescription Drugs	Prescriptive Advice and Treatment
Glass of water to calm self	Ben-Gay Alka-Seltzer Geritol Excedrin *Agua de Florida*+	*Melhaquaton*+ *Decatrol*+ Esidrex *Valium*+ *Aldomet*+ Hygroton "Calf Gelatine" (Knox Gelatine)	Given oxygen X-Ray Health screening No smoking Diet: 1200 calorie diet; must not eat food with fats; lower salt intake Take pulse -- if over 200 have palpitation problem Must not have strong emotional experiences

+Medicine or remedy from home country.

and that the physician was a specialist actively consulted. I found, however, several problems associated with the categories considered as treatment. Most respondents did not classify behaviorally oriented advice by physicians or friends as treatment. The strong belief in control over negative feelings or avoidance of upsetting situations, shown in the case of Rosa Flores, was in evidence among most respondents.

The tendency to reinterpret and reclassify symptoms appeared to have influenced the finding that persistent problems associated with the heart were taken to professional health care personnel. Rafaela Gil's *cólico de aire* (air colic) in the chest area, which had become a symptom associated with *presión alta* and *palpitaciones*, is now a disorder taken to the physician.

GASTROINTESTINAL AND GENITOURINARY PROBLEMS

The category of disorders associated with obstructions of the gastrointestinal and genitourinary tracts comprises some of the common illnesses which were usually treated within the household. The range of symptoms in this group was characteristically described in layman's language, such as "a burning sensation of the stomach" or "kidney disorders." Descriptions of these disorders reflect strong concerns about cleansing the stomach and purification of digestive and biliary juices.

Gastrointestinal and certain genitourinary disorders which involved the stomach, liver, kidneys, or bladder, characteristically were treated as everyday common problems. These were the household-managed disorders which were recurrent themes in inquiries about a person's health, and they constituted an area for which kin and friends always had some word of advice and wisdom. No one was free from the possible presence of some digestive problem. In contrast to the disorders of the blood and heart, which were life-threatening, digestive problems were part of the expected and normal occurrences of everyday life.

Men and women with gastrointestinal complaints usually described their symptoms as pain, gases, or nausea. *Padecer del estómago* (to suffer from stomach problems) also included descriptions of sharp pains, a "burning" sensation *(ardor)*, or acidity. Women, in particular, tended to complain of feelings of a swelling or fullness of the stomach and of nausea more than men did.

Liver malfunctions were frequently described as gases and sources of bad breath *(paladar amargo)* and anger *(enojo)*. Diseases classified as kidney problems *(padecer de los riñones)* included references to low back pain *(dolor en la cintura, rabadilla)*, infection, and a burning sensation at urination *(mal de orín)*.

Various reasons were offered for the presence of these disorders, but a central theme was engaging in some excess.

Overeating certain foods, such as fat, was believed to lead to digestive and liver disorders. Outbursts of angry demonstration of feelings which were normally expected to be under control were associated with *bilis* (biliary disorders). The heavy demands of work were frequently held as the triggering forces that caused the low back pains which were considered part of a kidney disorder.

The curing of these illnesses included a broad range of the latest home remedies, over-the-counter drugstore medicines and, in certain cases, the prescriptive advice of professionals from the health care system. These types of treatment highlighted, in particular, what Pineda has described as the highly dynamic character of household curing in Colombia. She notes that household-based curing practices are very popular throughout that country. The household is a center of diffusion for new medicines which it readily adopts or rejects, as in the case of antibiotics, purgatives, and vitamins. This household-based treatment is facilitated by the ease with which medicines and drugs are bought in pharmacies; from the widespread practice of self-medication and extension of prescriptive advice to others; from the custom of borrowing prescriptions which have proved effective for relatives or good friends; or from the use of leftover medicines for symptoms which appear similar to a case under consultation.[1]

In eliciting descriptions associated with the management of illness in the present study, I observed the constant changes on the medicine shelves of households, as advice about new medicines was adopted or rejected.

The use of antibiotic and sulfa home-based therapy was of interest. Symptoms identified as digestive, hepatic, and renal disorders were managed, at times, with penicillin or some form of Gantrisin*, without any understanding of the limitations or risks involved. As antibiotics and sulfa had become part of the medicines sold over the counter in drugstores in their home countries, for example, respondents had learned to depend on them for what they believed to be infections of the kidneys and related problems, as illustrated in the case of Roberto Peña.

The *Azo Gantrisin*** which he ordered from friends in his home country constituted a standing form of cure for the symptoms of low back pain associated with what he identified as a kidney disorder. His supply of the medicine was replenished by friends who returned from his country. When it was not available from this source, he "borrowed" from friends. He, as well as other respondents, used as many pills as necessary to relieve the symptoms. This pattern contrasts sharply with the prescriptive advice of U.S. physicians, who expect a patient on Gantrisin therapy to take a dosage with decreasing regularity over a specified period of days. Roberto's friends saved leftover antibiotics or sulfa drugs prescribed by physicians in Washington, which constituted a resource to be shared with kin and friends.

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*Gantrisin is a sulfa-based antibacterial drug.

**Azo Gantrisin is used for the treatment of urinary infections.

Tables 6-3 and 6-4 point to the range and types of treatment for digestive, liver, and kidney disorders. For digestive problems, there was reliance on antacids, various types of salts, and miscellaneous categories of medicines. Many of these were from the countries of origin. Home remedies such as tea or oil with honey were taken as complements to drugstore medicines. Antacids suggested by physicians were often similar to those which were self-administered by the respondents themselves.

Liver problems were managed with drugstore medicines such as antacids or home-based remedies to purify the hepatic juices. Those with perceived recurrent liver disorders avoided special foods, particularly eggs, fats, acids, fruits, and chocolate.

The range of medicines and remedies for kidney disorders was more limited than for stomach or liver problems. Characteristically, respondents had taken some home remedy such as lemon juice, to "combat excessive uric acid," or the sulfa-based drugs adopted from professional health care and drugstores. The case of Juan Cortés offers an illustration of the onset and management of recurrent symptoms of *mal de orín* which he had kept under control for a number of years.

TABLE 6-3

DIGESTIVE PROBLEMS: TYPES OF TREATMENT

HOME-BASED TREATMENT		SCIENTIFIC SPECIALIST TREATMENT	
Home-Based Remedies/ Advice	Over-the-Counter Drugstore Medicines	Prescription Drugs	Prescriptive Advice and Treatment
Tea	*Diasepan++*	Kaopectate	Low fat diet
Oil with honey	*Mezase+*	Donnatal	Bland diet
Milk	*Pepsamar+*	Gelusil and milk	Avoid egg yolks
Bicarbonate with lemon	*Taray+*	Various antacids	Injections
Lemon juice or "any other tranquilizers"	*Ether capsules+*	Suppositories	Upper G.I. series
Chan+	Alka-seltzer with carbonated drink	Iron	X-Ray
Special foods and drinks	*Sal de uvas Picot+*	Codeine ½ gr. #24, but did not take it	X-Ray, but not done because it cost $50
	Sal Andrews+	Cantil	Stool exam
	Sal de frutas+	Bentyl	Operation: cholecystectomy
	Pepto Bismol		
	Epsom salts		
	Mylanta		
	Gelusil		
	Espasmocibalgina+		
	Vitaminas Miadec+		
	Maalox		
	Balsamito+		
	Daily vitamins		
	Whatever is advertised on TV		
	Various pills and laxatives		
	Yodoclorina+		
	Iron		

+Medicine or remedy from home country.

TABLE 6-4

KIDNEY AND LIVER PROBLEMS: TYPES OF TREATMENT

HOME BASED TREATMENT		SCIENTIFIC SPECIALIST TREATMENT	
Home-Based Remedies/ Advice	Over-the-Counter Drugstore Medicines	Prescription Drugs	Prescriptive Advice and Treatment
Herbs	*Azogantrisin*+	Gantrisin	Lab work
Guarumo colorado+	*Urodonal*+	Ampicillin	Exercise
Lemon juice to combat uric acid	Vitamins	100 "Roche pills" but, took only 10	Injections
Wear girdle	Aspirins	Darvon 65	Operations
Rest	Lots of medicine	Capsules, name unknown	
Alcanfor and coramina+	"What people tell me"		
Avoid eggs, fats, acids, fruits and chocolate	Alka-Seltzer		
	Cibalgina+		
	Sal de frutas+		
	Coricidin (respondent believed it was an antibiotic)		

+Medicine or remedy from home country.

Juan Cortés, forty-three years old, had first suffered from a burning sensation at urination when he was twenty. When symptoms recurred every three or six months, he consulted a physician. The doctor's medicines did not cure him. Juan then thought that his illness was due to the water, since he drank from any available source, and he had no concern about "microbes." He also wondered whether the symptoms had started because he had entertained evil thoughts (*malos pensamientos*)*, or whether it was the climate. His wife finally gave him lemon juice, and the symptoms subsided. He believes that this juice has cooling properties which counteract the sensations of burning. At the time of this research, he had recently experienced a bout of *mal de orín* and wondered whether this had to do with some malfunction of his bladder, the indoor heating of his apartment, or the cold weather outside. He had taken some lemon juice and experienced a relief of symptoms.

The use of health care specialists was of interest because immigrants characteristically consulted them when they faced an acute onset or recurrence of symptoms as in the case of a sharp increase in "burning" sensations in the upper portion of the stomach or concerns about a swelling or bloating of this area. Latinos expressed confidence in the physician who diagnosed their complaints through a physical examination, x-rays, or other lab work. Those who had consulted various physicians for stomach disorders were critical of doctors who prescribed antacids such as Gelusil or Maalox, without a physical examination or other confirming indicators.

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*This expression carries the connotation of thoughts associated with sexual fantasies.

ILLNESS AND THE HOT/COLD THEORY OF DISEASE

The hot/cold theory of disease influenced a wide range of disorders at various stages in the course of diagnosis and treatment. But, a more narrowly focused group of illnesses was closely associated with the hot/cold theory. There were respiratory disorders, discomforts of the eyes, and musculoskeletal pains; yet, hot/cold was not an exclusive framework, to be sure. During the course of an illness the sick persons, kin, and friends frequently sought additional etiological conceptions, and they consulted a wide range of specialists. For persons with chronic muscular or joint disorders, the hot/cold theory provided a viable explanation, particularly in view of the apparent failure of popular and professional medicine to offer more satisfactory etiological explanations and cures.

Sore throats and discomforts of the eyes were frequently recurring symptoms. The broad range of muscular discomforts and disorders of the joints also constituted a category of illness held to be intimately associated with contrasts in temperature. This, however, was not a single explanation. The hot/cold theory served as the underlying framework which was retained as the immigrant examined a number of other prevalent theories. The hot/cold formulation served as an anchor as he consulted a broad range of specialists and tried wide-ranging forms of treatment. As an explanation associated with elements of the universe over which a person does not have full control, hot/cold appears to provide a concept about illnesses for which neither the popular nor the professional world has definitive notions of etiology or cure.

Working conditions frequently offered the context for the contrasts in temperature which led to the onset of respiratory ailments. Restaurant workers in hot kitchens, who had to make frequent entries into freezers, suggested that this type of work led to the recurrence of sore throats. Domestic workers who returned home on winter nights after working with hot appliances such as irons, also felt that their overheated bodies suffered from contact with the cold air and the result was frequent colds.

Persons with recurrent symptoms of the eyes as a "cold of the eyesight" *(resfrío en la vista)*, burning *(ardor)*, tired eyes *(vista cansada)*, or burning eyesight *(vista acalorada)* usually had more than one etiological explanation: Exposure to heat or to air conditioning, ingestion of wrong foods, microbes, and/or excessive concentration on a problem. Persons with *vista cansada*, in particular, viewed their problem as one which was symptomatic of possible poor eyesight together with the draining effects of fatigue or worry. For example, when Beatriz Luque went back to her Central American country for a month's vacation, she consulted an oculist for her persistent symptoms of *vista cansada*. After the eye examination, the oculist indicated that her reading glasses were adequate. Both Beatriz and the specialist agreed that what she had was *cansancio de la vista* caused by a six-day work week in the United States and the rushed life she led. At the end of her vacation, her symptoms disappeared. She attributed this to rest, and to the use of water with lemon drops to rinse her eyes in the morning. Lemon was believed to have cooling qualities to counteract the heat in the eyesight.

With regard to the treatment of respiratory ailments, Table 6-5 indicates a heavy reliance on home-based management, particularly drugstore medicines such as Bufferin and Contac. Immigrants also used antibiotics such as Tetracyclin which were part of the store of medicines introduced from their countries of origin. Self-prescribed antibiotics were typically taken until the symptoms subsided.

Discomforts of the eyes were alleviated with eye drops or by some particular action such as rest or less television

TABLE 6-5

HOT/COLD DISEASES: RESPIRATORY AILMENTS AND DISCOMFORTS OF THE EYESIGHT TYPES OF TREATMENT

HOME-BASED TREATMENT		SCIENTIFIC SPECIALIST TREATMENT	
Home-Based Remedies/ Advice	Over-the-Counter Drugstore Medicines	Prescription Drugs	Prescriptive Advice and Treatment
Lemonade	Dristan	Penicillin	Change of glasses
Water with lemon drops+	Contac	Unknown medicines	Long-ago physician suggested that tonsils be removed; instead takes self-prescribed Tetracyclin
Lukewarm water with salt	Vicks Formula 44		
Drink something hot such as *"cafe con leche"*	Menthol tablets		
Herbal infusions+	Bufferin		
Boiled eucalyptus leaves+	*Tetraciclina+*		
Flor de chula con aspirinas+	Other self-prescribed antibiotics		
Inhale heated Vicks	*Vizina+*		
Take bath	*Astringosol+*		
Cover up	*Alergizona+*		
	Pomada de Terramicina+		

+Medicines or remedy from home country.

viewing. Eye drops or other medicines were sometimes believed to have hot/cold qualities which benefited their eyesight. Emma Gonzales, for example, used a drugstore remedy from her country which offered relief for her burning eyes. These were "calcium drops" based on *suero** for the overheated sight and burning eyes. They "refreshed the eyesight" *(gotas de calcio a base de suero para la vista acalorada y el ardor en la vista; refrezcan la vista)*.

Muscular aches or joint pains constituted a broad group of recurrent and long-term illnesses. There were transient manifestations of tenderness localized in a specific body area such as a shoulder, knee, or finger joint. Persons with medically diagnosed rheumatoid arthritis described persistent pains, swelling, and stiffness.

Explanations offered for the recurrence of these symptoms focused particularly on contrasts in temperature, but some respondents also gave a variety of other etiological conceptions as causal explanations. Some had heard that malfunctioning of the kidneys was an aggravating factor in rheumatic disorders; others had heard that poor circulation and lack of calcium or iron contributed to the onset of inflammation of the joints. Many asked themselves whether

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*As used here, a normal saline solution.

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hard work, nerves, or family hereditary factors had not exercised some influence on the nagging quality of the symptoms.

With regard to treatment, Table 6-6 shows that respondents used various types of home-based treatments as well as medical advice. Home treatments included the use of analgesics and special medicines for rheumatism, some of which were brought over the counter in their home countries. Men and women made a more extensive use of various forms of massaging for their aches and pains than for any other problem described in this research. This was done usually with some type of oil or with Ben-Gay or Vicks. The specialist in massaging was typically a relative, the spouse, or a good friend. Selected cases, followed over time, showed certain salient aspects of muscular aches and diseases of the joints.

The case of Eugenia Suarez, discussed below, illustrates the flexible nature of the medical belief system, as she made the culture of her host society fit with her traditional conceptions. For some of the immigrants, there was an interpenetration of uncontrollable interpersonal events and crises with symptoms associated with hot and cold. This was evident, in particular, among men and women with strong affective investment in family and work roles. The cases of Carmen Gonzalez and Alberto Rodríguez, also discussed below, point to critical dimensions of their illnesses

TABLE 6-6

HOT/COLD DISEASES: JOINT PAINS/MUSCULAR ACHES -- TYPES OF TREATMENT

HOME-BASED TREATMENT		SCIENTIFIC SPECIALIST TREATMENT	
Home-Based Remedies/ Advice	Over-the-Counter Drugstore Medicines	Prescription Drugs	Prescriptive Advice and Treatment
Drink hot water	Arthritis Formula	*Butazolidina*+	Blood tests
Lemonade	Vitamins	Various tranquilizers	Urine tests
Novena of special herbal teas+	Bufferin	Inducin	Rest
Rest	Aspirin	Darvon 65	Exercise
Go to bed early	*Eucalyptus liniment*+	Ascriptin	Apply heat
Hot bath	*Reumafin*+	Librium	Use cane
Apply heat	*Cogajin*+		Change mattress
Wrap shoulder in hot towel	*Balsamo Algecide*+		Special stockings
Wrap feet in wool cloth	*Parches* (poultices)		Special corset
Lukewarm compresses			Refer to rheumatology clinic
Rubdown with Vicks			Various types of injections
Massage self			
Others give massage			
Ben-Gay applications			
Soak in Epsom Salts			
Snake lard+			
Various pomades+			
Avoid temperature changes			
Infrarub applications+			

+Medicines or remedy from home country.

as they maintained high aspirations for themselves or their significant others. Their personal misfortunes and puzzling illnesses clearly stood in the way of attaining these desired objectives.

Eugenia Suarez did not abandon her belief about the hot/cold theory when she learned from a friend that impurities in the blood and a high level of uric acid were the factors which contributed to her rapidly developing symptoms of *reumatis* (rheumatism). The seasonal changes in the Washington environment were quite different from the dry and rainy season cycle of the home town where she had learned to identify the hot and cold qualities in food and medicines. But part of her adaptation to Washington included the identification of comparable cultural forms to which she could ascribe the qualities of hot or cold.

We once spoke together about the reasons for not complying with the advice of a physician that she apply a heating pad to her back every morning before going to work. She explained that, following a morning's application of heat, she did not want to expose her body to the cold drafts in the bus in which she rode to work. Although she had not used electric heating pads in her country, she had rapidly adapted the hot/cold conceptual framework to the objects used in the Washington environment.

Carmen Gonzalez complained of back aches, localized around her coccyx *(la rabadilla)* and in her left shoulder.

The physician in Washington prescribed periodic applications of wet heat. While she followed this treatment she also used Arthritis Formula and Ben-Gay to rub on her shoulder and her cousin gave her periodic massages.

The year following my first contact, I visited Carmen Gonzalez in Washington. She returned to her home in Latin America and I also met her there. While in the United States, Carmen had often wondered what had originally precipitated the onset of *dolores de la rabadilla* (tailbone aches) and her shoulder aches. At times she thought that it might have been an incident two years prior to her visit to the physician, when she had come in from the street in an overheated condition and had stepped into a cold shower.

In her home city she described an episode which had occurred soon after her return home. One day, as she rushed up a flight of steps she experienced such an acute pain in a knee that she was not able to continue up the stairs to meet a prospective employer. After an hour of rest she went home and her mother massaged her. She also consulted a physician who suggested that she might have rheumatoid arthritis. He sent her for blood work and later indicated that the results of the sugar and blood tests did not confirm this suspected diagnosis.

Carmen's discussion of past episodes of illness suggested that incidents associated with difficulties in body movement have occurred at about the same time as she met some interpersonal crisis. A few years before, she had experienced a "dislocation" of the neck muscles. This had occurred on the day that she had discovered her husband with another woman. After a long crying spell following her discovery, she went to a neighboring town on an errand. On the way back, she felt feverish and, while walking home, was caught in a downpour of rain. She arrived home and experienced the "dislocation" which she felt might be what she had heard described as *derrame* (cerebral hemorrhage).

Carmen went to a physician and, after some discussion, she concurred with his advice that she should avoid "strong emotional experiences." A good friend advised her to go forward *(siga adelante)* and live her life. Although she subsequently separated from her husband, she had not found this an easy step to face. She has a difficult time earning a living at the level which permits her to give her children the best educational opportunities available. She wants them to have a better life than she and her family have had.

At the time that Alberto Rodríguez was first interviewed, he sought relief for pain "over his whole body" but particularly for a stiffness of the neck and back and for swollen finger joints and knees. He associated an increase in impairment of movement with the onset of cold and dreary days *(días fríos y nublosos)*. To relieve his discomforts he had taken hot baths, had been massaged with Ben-Gay, and had taken various analgesics.

During the course of a year of continued research contacts, Alberto described new theories he had learned about his illness. Friends told him about the need for calcium to strengthen his bones; others talked about the need to take lemon juice to keep his uric acid from poisoning the blood. He had read popular articles about arthritis, and he often expressed the wish that someone would offer a definitive cure for his illness.

He was treated at various rheumatology clinics. First he went to a clinic in a private hospital, but he missed appointments during periods when he could not pay. When his illness became acute, he had to take time off. This resulted in loss of income because he was not covered by sick leave privileges, and so he withdrew from the clinic. I suggested that he attend a publicly supported community clinic which covered his area of residence. He went there for an initial visit but stopped because an intake interviewer asked him "to go back home" to bring proof that he actually lived at his reported address. She had told him that "too many people were giving her fake addresses to qualify for services when they did not live in the right boundaries." He went home vowing never to return because his word had been doubted. I referred him then to the private outpatient services of a teaching hospital. He attends this clinic now, though he frequently wonders why it is that so many different staff members examine and measure him as if he were a guinea pig *(conejillo de Indias)*. It makes him wonder if the students come to observe and to measure the "progress of an incurable disease."

Towards the end of my research, Alberto described his low spirits. He felt "defeated and with a complex about limping and having the face of a sick man" *(me siento abatido y acomplejado de andar renco con cara de enfermo)*. He began to refuse invitations to join friends for social activities. A major concern had to do with his work potential and role as a major source of support for his family. He had always taken the responsibility for everything in his household *(siempre he sido el responsable por todo)*, and it was obvious both to Alberto and to me that this role had become increasingly difficult for him to fulfill.

Alberto's case, as well as the findings on the four categories of disease, point to specific ways in which cultural beliefs manifest themselves in symptoms of illness and in their management. The Latino concept of prevention frequently focuses on disorders of the blood. Conditions associated with the blood require attention in order to prevent serious organic and psychological disturbance. In addition, even when a person undergoes treatment for a serious illness such as cancer, Latinos believe that proper attention to the blood is necessary to prevent further development of disease.

Symptoms associated with the functions of the heart, such as palpitations, are believed to be indicators of strong emotional experiences. There were few manifestations among the research population of the syndrome of *susto* (magical fright) which has been frequently described in the anthropological literature on Latin America and is discussed in Chapter 2. It is quite possible that Latinos in Washington find that the vocabulary of cardiovascular symptoms seems more acceptable to express certain strong emotional experiences in the new setting than the language of fright or fear.

A related aspect requires attention. Some Latinos who were confirmed hypertensives were trying hard to understand the nature and etiology of their problem. The cases described in this chapter suggest that technical explanations alone, such as systolic-diastolic rates or cholesterol levels, are not very helpful for this purpose. Increased knowledge by health workers of the influence of Latino cultural beliefs and practices regarding hypertension and coronary disease should facilitate explanation and cooperation with medical regimes for these problems. To the writer's knowledge, these data are not available for Latinos in the United States or even in Latin America.

The everyday illnesses of the digestive, biliary, and genitourinary systems are those for which household members and trusted friends play a central role as sources of prescriptive advice or dispensers of medicine. The Latino household appears to exercise a stronger influence on the identification and management of illness in Washington than in Latin America because there are no resources in the urban centers of the United States which are as readily available to offer diagnostic impressions and medicines as was the pharmacist or drugstore owner in the home country. Members of immigrant households and their trusted friends, who continue to receive from the home country such medicines as patent remedies or antibiotics, do not usually consult about dosage with professional health workers, as they did at home.

The hot/cold theory pervades a wide range of diseases. The syndromes which are frequently associated with the theory, however, appear to be those for which the popular or biomedical traditions have limited control. Follow-up among persons with recurrent or chronic musculoskeletal complaints indicates that the hot/cold idea supplies "the answer" when all other medical explanations or cures have failed or have shown limited effectiveness. While a Latino or Latina "shops around" for satisfactory treatment, this theory offers an anchoring system with its associated notions of etiology and curing.

The four categories of illness described in this chapter underscore the interrelationship of cultural, physical, and psychological factors which characterize

Latino concepts of illness. These linkages were evident in beliefs about prevention, the management of life-threatening syndromes, diagnoses and treatment of common everyday illness, and the persistent search for relief of symptoms in chronic diseases for which no ready cure appears to be available. The following two chapters present specific findings on levels of stress and sociocultural characteristics, and the use of *controlarse* as a central mechanism for the management of symptoms of emotional disturbance.

CHAPTER 7

THE HEALTH OPINION SURVEY
AND MEASUREMENT OF STRESS

A number of mental health surveys show a high prevalence of psychiatric symptoms correlated with certain demographic and sociocultural conditions. A. H. and D. C. Leighton indicate that the majority of these disorders are minor, involving persons who are impaired to no more than a mild degree, rather than the severely incapacitated or psychotic. They emphasize the importance, nevertheless, of giving attention to data which identify levels of impairment, since even minor disorders may interfere to a significant extent with the expectations and activities of daily living. Information of this kind is particularly useful because psychiatric symptoms do not appear to have a random distribution. There are differences in prevalence by such categories as age groups, socioeconomic levels, organization of living environments, and sex of the subject.[1]

I am particularly interested in the study of the social, cultural, and demographic characteristics of the psychiatric symptomatology among Latinos because few such studies have been conducted among them. My more specific interests, however, are related to the need to complement qualitative findings about culture, symptoms of malfunctioning, and their management with quantitative material which can help to identify high-risk and low-risk groups in stress situations.

Comparisons between the symptom patterns of immigrants in the community group and those in the school parent group were of special interest. On the whole, respondents in the community were believed to be at greater risk because they had lived in the United States for a shorter period than the school parents.* Four out of ten persons in the community group (41.7 percent) were in the unsettled illegal alien status, and this factor could hardly help creating insecurity or anxiety. Most school parents, on the other hand, were no longer faced by the demands of initial settlement in the city.** Although the health and mental health status of the school parents prior to this research was unknown, it was believed that, as established immigrants, they would have lower levels of stress than the community group.

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*As indicated earlier, over half (53.7 percent) of the school parents had been in the United States six years and more, while only 16.7 percent of the community group had been in the country that long.

**The immigration status of school parents was unknown. It was the writer's impression, however, that there is a tendency for Latinos in Washington not to bring children under eighteen to the city until the parents have attained a certain stability, including the attainment of permanent residence.

THE STRESS MEASURE

The twenty-question Health Opinion Survey (HOS) instrument used for the present study was derived from a set of seventy-five questions prepared by A. Macmillan for use in the Stirling County study. It was standardized among Eastern Canadians who ranged from the well-to-do to the poverty-stricken. The original test was built up from several sources, including questions from the Army's Neuropsychiatric Screening Adjunct and others from post-World War II screening instruments which were reported to be useful neurotic discriminators.[2] Questions concerned chiefly with psychoneurotic and psychophysiologic symptoms were included.

This research was part of Cornell University's Stirling County study under the direction of A. H. Leighton.[3] Following their use in the study, all of the screening questions were analyzed against independent psychiatric evaluation. The twenty that agreed best with the psychiatrists' judgments were selected and became known as the Health Opinion Survey of mental health, shown below in Appendix C.

The instrument was revalidated in Canada by comparing an individual's score with a psychiatrist's direct assessment of the same person's mental health status without the psychiatrist's knowing the score. No coefficients of correlation were offered, but there was major agreement between the survey results and the independent psychiatric ratings.* Spiro, Siassi, and Crocetti further validated a shorter form of the HOS in a Baltimore probability sample representative of a population of United Auto Workers members.**

The HOS has a simple scoring system with a total range of twenty to sixty. There are standard questions as to symptoms and standard answers -- either Yes/No, or, Often/Sometimes/Never. The Yes or Often ("sick") answer receives a score of three, the No or Never ("well") answer a score of one, and the intermediate answer (or no answer) a score of two. The range of scores (twenty to sixty) thus shows that the lower scores are usually associated with the

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*A.H. and D.C. Leighton and R.A. Danley ("Validity in Mental Health Surveys," p. 175) state that no coefficients of correlation were offered "because the product moment correlation which is generally used in making comparisons for instruments such as the HOS requires the assumption that one is working with a representative sample of a defined population." In the sample used for their survey, the investigators placed an emphasis on selection of extremes. In the Stirling County study, the relationship between the ABCD ridit (based on all the symptomatology reported in a protocol), the Total Impairment ridit (psychiatrists' estimates of the extent of disability from psychiatric cases) and the HOS scores were also considered by age and sex. The HOS trends parallel the evaluation ridits, being a little closer on the whole to impairment than to ABCD. (For detailed statistical presentation of these analyses, consult D.C. Leighton *et al.*, *The Character of Danger*, pp. 253-295).

**These authors used thirteen questions which showed greatest discriminator-capacity in extensive pretesting and prior studies. For details on the statistical analyses, consult Spiro, Siassi, and Crocetti, "What Gets Surveyed in a Psychiatric Survey?" pp. 105-113.

absence of psychiatric involvement and higher scores with evidence of "psychiatric disorder."[4] *

The HOS is particularly useful in identifying physiological or bodily symptoms which are common reactions to stress and overall reactions to stress. The respondent's answers report his symptoms *as he experiences them*. Thus the answers register the presence or absence of psychoneurotic and psychophysiological symptoms. It is assumed that the majority of people who suffer mild psychiatric disorders associated with all kinds of environmental stress will exhibit principally these two kinds of symptoms. That is, the questions represent a sampling of the normal initial human reactions to something perceived as dangerous or stressful.[5]

In using this instrument, the concept of identified symptoms or symptom patterns is essential to an understanding of indices of impairment. Behavioral phenomena are referred to by the detailed symptom pattern labels, and they are considered fundamental units for the study of psychiatric disorder and mental health, rather than diagnostic

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*Three levels of HOS scores have been used in several studies to suggest possible clinical significance:

Normal Range	20-29
Borderline (Middle)	30-34
Increased Stress (High)	35-60

Whether these levels should be modified for Latin American subjects is not known at present.

categories.[6] The development of symptoms constitutes a reaction to underlying conflict in a person's psychological condition, together with the defenses used to cope with this conflict.[7]

Symptoms not only signalize a single individual's impairment and reaction but they reflect culturally defined expectations as well. A. H. Leighton points out that depression and anxiety, for example, may not be considered illness by specialists and laymen in some situations. But it might be significant also if the individual *failed* to experience certain feelings or to show certain behavior under appropriate conditions in a particular culture. He suggests, therefore, that the cultural influence in symptom patterns must be taken into account in interpretation of results in which sociocultural factors and symptoms are associated.[8]

The twenty-question scale has been used for various purposes and in various settings. It has been part of research studies in Nigeria, Peru, and Puerto Rico; it has been used with Black and White respondents in Florida and North Carolina.[9] The translations of the instrument have been assessed, with careful attention to several considerations, as shown in the study *Psychiatric Disorder among the Yoruba*. These include such factors as: (1) to see how the instruments and the evaluation procedures work in practice with the specific group under study; and

(2) to see what the results provide from the psychiatric point of view. Consideration is given also to the changes needed to convey the meaning of the original questions as accurately as possible.[10] For the Spanish translation of the HOS used in the present research, I examined the version used in a Peru study[11] and pre-tested several versions prior to actual use. In addition, attention was given to the use of language best fitted to the backgrounds and specific Latin American heritage of the respondents.

There are two well-known examples of the use of the HOS among Latin Americans, one in Puerto Rico and the other in Peru. Rogler and Hollingshead used the instrument in San Juan, Puerto Rico to differentiate schizophrenics from neurotics and to distinguish clinically diagnosed "sick" individuals from a normal group.[12] Kellert *et al.*, used the HOS in rural Peru to examine relationships between cultural change and stress.[13] These authors indicated that, although wide cross-cultural differences in patterns of behavior and in the way people describe their illnesses should be expected, direct reports on physiological symptoms seemed to be less subject to cultural influence. The findings of the Peru study fell into patterns that resembled those found in other parts of the world where validation studies have been made.[14] An aspect of interest is that separate factor analyses of the responses of males and females in the Peru research led to discarding four items. Smoking proved to be either unrelated or negatively related to the other stress items. Three items dealing with headaches and nausea were also eliminated because, for women, they formed a separate factor.

A factor analysis of the responses of the Latinos in the present research showed that eighteen of the twenty HOS items were intercorrelated. Item 7 (stomach discomfort) and item 11 (smoking) did not correlate with any items. The analysis also revealed questions with high loadings on two factors which I have called "hypochondriasis" and "anxiety." The subscore on "hypochondriasis" included such questions as whether the respondent was bothered by various ailments, felt weak all over, or was tired in the morning. The subscore on "anxiety" included questions which dealt with hand trembling, heart beating hard, upsetting nightmares, and "cold sweats."* Mean scores were obtained for the data on three dimensions: (1) mean scores of the HOS based on eighteen items; (2) "hypochondriasis" score; and (3) "anxiety" score. A more detailed analysis of these findings will be published separately.**

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*HOS questions in the "hypochondriasis" subscore: Numbers 5, 10, 13, 14, 17, 18. For the "anxiety" subscore: Numbers 2, 4, 8, 9, 12, (See Appendix C.)

**Professor Antanas Suziedelis, Ph.D., conducted the factor analysis. Mary Louisa Luna, M.A., assisted with computer analysis.

I decided, however, to retain the scores based on twenty questions for presentation and discussion in this chapter, in order to make possible comparison with other research which has used the original number of HOS items.

HOS FINDINGS

The overall mean HOS was 27.8 (within normal limits), with a standard deviation of 6.49. The range of scores extended from 20.0 to 54.0 (Table 7-1).

Levels of Stress and Illness

As expected, the overall mean score of persons with a health problem was higher (30.0) than that of persons who reported that they were not experiencing a health problem (23.7).

Respondents in the middle- and high-stress groups made up 28.9 percent of the total population. School parents (whose health and mental health status were unknown prior to the study) constituted only a quarter of the high-stress respondents (Table 7-2). In addition, there was a smaller proportion of school parents in the intermediate stress level. Community respondents who were more recent immigrants were, as expected, at greater mental health risk. This contrast between populations is of central importance since it draws our attention to the differences between Latino groups. Length of residence

TABLE 7-1

DISTRIBUTION OF MEAN HOS SCORES BY GROUPS, SEX, AND PRESENCE OR ABSENCE OF HEALTH PROBLEMS

Attribute	Mean Scores		
	Mean Score	Highest Score	Lowest Score
Mean Score for Total Group (n=97)	27.8	54.0	20.0
Mean Score by Presence or Absence of Health Problems			
Yes, Health Problems	30.0		
No health problems	23.7		
Mean Score by Sex and Group	Male Mean Score		Female Mean Score
Overall Group	27.7		27.8
Community Group	31.1		28.0
School Group	23.8		26.5

TABLE 7-2

DISTRIBUTION OF STRESS LEVELS BY GROUPS (PERCENTAGES)

Stress Level	Type of Group	
	Community (n=48)	School (n=49)
High Stress	18.8	4.1
Intermediate	25.0	10.2
Normal Range	56.3	85.7

and the kind of settlement in the new setting are variables which should be carefully assessed in more extensive studies of culture and mental health status among members of this minority group. Furthermore, linkages between physiological and psychological symptoms should be identified, as noted in findings about the use of medical resources by both the school and community respondents found in the middle- and high-stress groups.

At the time of the study, all but one of the middle- and high-stress persons were using some type of health resource, usually a private physician or inpatient hospital facility. Their discomforts included gastrointestinal complaints, conditions identified as "nerves," rheumatism, or various body aches. Hospitals had been used for gynecological procedures such as dilatation and curettage or for injuries resulting from an accident. None of these adults were using mental health resources. Some parents whose children had presented behavior or learning problems in the schools had been referred to such agencies, but at the time of this study, they were not using them.

The two highest scoring respondents among the school parents (with scores of 44 and 43) were two women who had their husbands and children with them in Washington. One woman (age forty-six) worked full time, and she reported as her only health problem longstanding symptoms of "nerves" and headaches. In the past, these had been treated by a physician with Librium (10 mg.). At the time of the study, she was using a medicine mailed from her home country which she said relieved her headaches but increased her "nerves."

The second woman (age thirty-four) appeared to be overwhelmed by the crisis precipitated by news of the impending marriage of her seventeen-year-old daughter, who was still in the home country. The news had brought back memories of her own troubled first marriage when she was fifteen. During the interview in which the HOS was administered, she described her depressed feelings, her loneliness, and a general state of suffering. She felt that her stomach had become swollen as if she were with child. A private physician had given her some medicines which she had stopped taking because she feared that this would increase the uric acid which contributed to her gastrointestinal complaints. She was one of the women who believed that her character had been damaged (*el caracter se me ha danado*) from the use of birth control pills. A physician had told her that her husband ought to use some birth control measures, but she had not been able to convince him of this. The physician, who was also of Latin American origin, was reported to have told her that she would then have to help herself and her moods by showing *fuerza de caracter* (strength of character) through which she was expected to hold back her disturbing feelings.

The two highest-scoring respondents in the community sample (scores of 54 and 52) were Luisa Guerrero, a forty-seven-year-old single mother, and Alberto Rodríguez, the divorced man with rheumatoid arthritis whose plight was described in earlier chapters. He was forty-three-years old.

Luisa lived in a suburban apartment with three of her five children, whose ages ranged between fourteen and twenty-one.* She worked as a domestic with annual earnings in the $3,000-$3,999 range. In earlier years, she had worked as a live-in maid at a lower salary. She was constantly worried by thoughts of the future of her children if something should happen to her health or to her income-producing opportunities. At times she felt very tired of her routine of getting up early every morning to catch the seven o'clock bus that took her to the households where she worked. Luisa suffered back pains and some arthritis, and she experienced periodic gastrointestinal discomforts. These had been treated largely by private physicians.

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*Her two oldest children, who were in their mid-twenties, were in her home country. Towards the end of this research, Luisa brought these children to Washington.

One of her girls had been crippled by polio as a child and had some limitation in the use of an arm and hand. Two of her children were completing high school, and one had entered college part time. Two others, who remained in her home country, had also finished high school and had taken some specialized courses in commercial subjects. Luisa was saving money to have these children join the rest of the family in Washington.

With regard to Alberto Rodríguez, as noted earlier, he appeared depressed and voiced fears about his future ability to work and his increasing physical incapacity from the crippling effects of his disease. He was concerned also about a daughter who was experiencing marital problems, which he associated with her husband's increased bouts with alcohol.

Sex and Stress

The relationship between respondents' sex and responses to stress is of interest, since this has been an area of some discussion in the literature. The Peru study found that women tended to report more symptoms than men.[15] This was the overall finding also in the Stirling County study, although analysis by age groups suggests that differences were exaggerated or diminished at particular ages along the life span.[16] The mean scores for men and women in the present study were almost identical: 27.7

and 27.8 respectively (Table 7-1). This agrees with the Midtown Manhattan Study[17] in finding no difference between men and women in average mental health risk.

The fact that in Washington both men and women appear to be subject to similar adaptive necessities in relation to the family and to work may be an important equalizing factor in these findings. Although men and women had been exposed to different educational and socialization experiences in their countries of origin, they tended to face quite comparable tasks in the new environment. The migration experience usually involved the initial move of single individuals, men or women, rather than families as a unit. Thus, members of both sexes must cope with separation from the family, and, once in the United States, they work towards the goal of its reconstitution. In addition, most men and women are highly committed to full-time work, sharing common values about its importance for their personal and family advancement.

Analysis of the mean scores of men and women by community and school parent groups, however, points to factors about length of residence and household organization which may influence differences in responses to stress by sex. Men from the school group had the lowest mean score of all groups (23.8). Moreover, their scores contrasted with those of their male counterparts in the community group, who averaged 7.3 points higher (31.1).

(See Table 7-1). Women in the school group also had lower scores than women in the community group (26.5 versus 28.0), but the contrasts were not so marked as between the male groups.

These differences between respondents from the subgroups may reflect contrasts in their length of residence in Washington. As stated earlier, over half of the school parents had been in the United States six years or more, while less than one-fifth of the community group had been in the country for that long. Thus men in the community group may well be particularly at risk during the process of settlement. A critical dimension in the mental health status of these more recently arrived community men appears to be the presence or absence of the spouse and children.

While men in the school group lived in a nuclear or extended family, with the spouse and most of the children under eighteen with them, men in the community group, for the most part, were separated from their families, who had remained at home. Most of these community men were illegal aliens, and it was not easy for them to bring spouse and children to Washington.

Women from the school group had most of their children under eighteen with them, whereas community women tended to have left their younger children in Latin America. Women as mothers, however, follow paths within the household which differ from the family careers of men. Latinas may be part of a conjugal unit, or they may be heads of a single-parent household due to the circumstances of widowhood, separation, divorce, or unmarried parenthood. Men in Latino society are seldom single-parent heads of household.* Mothers are expected to exercise greater emotional self-reliance than fathers. These expectations may have enabled women in this study to cope somewhat more successfully with the absence of spouse and children than men.

Age and Stress

Table 7-3 shows that respondents in the 25-29 age category had higher scores than any other age group (mean score, 31.4). These findings were somewhat puzzling at first because several studies have pointed out that there is a tendency for stress to rise with age. Two aspects of the life situation of the 25-29 age group appear to be pertinent.

1. Most migrants in this study first entered the United States while in the 25-34 age range. Some of those still in the 25-29 age group when studied were experiencing difficulties associated with their first years of

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*It might be recalled that the only man in the study who was a single parent (due to divorce), remarried while this study was written.

TABLE 7-3

ALL IMMIGRANTS: DISTRIBUTION OF MEAN HOS SCORES BY AGE, MARITAL STATUS, AND EDUCATION

Demographic Characteristics	Mean Score
*Age**	
15-19	25.5
20-24	25.0
25-29	31.4
30-34	27.9
35-39	25.5
40-49	28.6
50-59	28.1
60 and over	28.3
Marital Status	
Childless never married	29.7
Single parents	28.6
Married	27.8
Widowed	26.6
Separated	27.0
Divorced	26.0
Education	
None	31.3
Some primary	29.7
Complete primary	26.6
Some high school or technical	26.4
Complete high school or technical	26.9
Some college	29.1
College graduate	31.0
Unknown	22.0

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*Analysis of the age groups between fifteen and forty by five-year intervals was based on the original assumption that most respondents would fall in these categories. I had expected to find few respondents in the forty-and-over groups, so I used ten-year intervals.

settlement. This 25-29 age group, in fact, was composed almost totally of the more recent community arrivals. Only one school parent was in this age group, and this person was the youngest of all school parents.

2. A second critical factor is marital status for this age group, mostly single, as noted below in the discussion of marital status and stress.

Table 7-3 shows that, overall, the age group between twenty-four and forty showed fluctuations which may chiefly reflect individual variation in length of residence. If it takes approximately seven years to reconstitute a household and to begin to feel a full member of the host society, as was the case among members of the Mora family, the strains and moments of relaxation of this phase may be reflected in the HOS scores. From the age of forty on, slight increases were noted, particularly for the 40-49 age group. This is suggestive of menopausal changes among women.

Marital Status and Stress

Table 7-3 shows that the childless never married had slightly higher mean scores (29.7) than single parents who had never married (28.5) and than married persons

(27.8). Those formerly married had lower scores than any other group.

Differences in the scores of the formerly married and of single parents who had never married may have been affected by several factors. Although the divorced and the widowed, for example, were of an older average age (47.5 years) than all other groups of respondents, most of them were settled with their children only, and these children tended to be in the over-ten age group. The single never married parents appear to have had greater difficulty in carrying the multiple role responsibilities of their status as mother and head of household, even though many had kin such as a parent or other relatives living with them. Some of their children were still nine and under. It appears as if widows and divorced women, who were in the middle age groups which showed slight increases in HOS scores, were more independent than the single never married parents. They may have been able to cope more effectively with the demands of single parenthood and child-rearing than parents who had never married. The question merits more extensive attention.

Data about the childless never married are of interest since the literature presents variations regarding stress levels of this category as compared to the married or the formerly married groups. Almost all of the childless never married men and women were part of the younger community sample population of 25-29 (mean HOS score 29.7).

In Chapter 3, it was stated that this young group had higher levels of education than most other respondents. Gaps between their aspirations and their actual occupational achievements in Washington appear to have been factors contributing to their stress. One of them, Eugenia Suarez, was the elementary school teacher who had adopted the fictive role of the poor working mother upon arrival in the Washington area, in order to avoid unwanted attention from men on her job as a waitress. She described sensations of suffering, nevertheless, and wondered whether this had precipitated her *reumatis* (rheumatism). Alicia Contreras, the secretary who had become a full-time domestic worker, was also in this group. Although she had initially tried to use her typing skills, she had developed marked symptoms of anxiety and fears about the possible death of her elderly parents in her home country.

It is quite possible that for the childless never married the postponement of marriage may have also accentuated some of their stresses, particularly in connection with the goal orientation needed during the period of settlement. One of the notable characteristics of the population in this study was that most men and women had left their places of origin *after* they had begun to establish their households and to have children. While this created disjunctions in the households and in family relationships, it appears to have given immigrants clear notions of purpose and goal in their work for the re-establishment of households in the host society. For most of the childless never married who were currently experiencing the frustrations of lowered status, the postponement of marriage may have deprived them of anchoring groups, reinforcing goals, and other social supports to withstand the normal demands of settlement.

Education and Stress

With regard to education, Table 7-3 indicates that persons with incomplete primary school (mean score 29.7), as well as those with post-secondary education (mean score 29.1) offered evidence of greater stress than persons in the middle range, composed mostly of those who had complete primary school (26.6) or had some high school education (26.4). Community respondents tended to have a more limited education than school parents. Over twice as high a proportion of the community group as the school parents had only some primary education. As in other studies made in metropolitan centers, low educational status appears to contribute to the experience of stress. However, an explanation is required for my findings, which show that the small best-educated group, drawn principally from the school parents, had scores in the same range as those with very little education. There is only limited

TABLE 7-4

ALL IMMIGRANTS: DISTRIBUTION OF MEAN HOS SCORES BY OCCUPATION AND WORK CHARACTERISTICS

Occupational Characteristics	Mean Score
Occupation	
Major professional	31.0
Small business	25.8
Clerical	24.3
Skilled	25.4
Manual, semiskilled	26.5
Unskilled	28.9
Not working	27.2
Single or Several Jobs	
Yes, more than one job	29.3
One job only	27.1
Not working	27.2
Interest in Change of Occupation	
No information	25.5
Yes, want to change	28.6
No change desired	26.5
Not working	27.2

information about the psychological status of Spanish speakers in general who have acquired specialized education and skills. For those with such qualifications it may well be that the frustration associated with gaps between skills and achievement accounts in part for the higher than expected level of stress.

Occupation and Stress

An area of special interest is the comparison of occupation and stress levels, in view of the high commitment most respondents held to work. With the exception of the one person in a professional occupation, the 54.6 percent who worked in unskilled jobs scored higher (28.9) than those in other categories (Table 7-4).

These findings are particularly significant when viewed along with data about time devoted to work and interest in change of occupation. Persons who worked full time and also did supplementary work evenings or weekends had higher scores (29.3) than those who worked only full time (27.1) or those not working at all (27.2). Since adults complained about difficulties in their jobs, such as *mal trato* or limited benefits, I compared the stress levels of persons who wanted a change of occupation with those who expressed satisfaction in their jobs. Table 7-4 shows that those who wanted to change occupation (two-thirds of the total working population) had higher mean scores (28.6) than those who felt satisfied with their jobs (26.5). (The proportions of community and school parents who wanted to change occupation were about equal, with 60.42 percent of the community parents and 55.1 percent of the school parents in this category).

These findings should be emphasized, inasmuch as they indicate important relations between work and mental health both for recent immigrants and settled Latinos. They offer complementary information for detailed case analysis regarding aspirations about work. Plans for change within a job, or between jobs are central topics of concern in the lives of a sizeable proportion of respondents. The goal of holding a single, sufficiently rewarding job is difficult to attain, and the strain of achieving a satisfactory income through multiple jobs is great. It seems clear that the mental health implications of the goodness of fit between occupational activity, aspirations, and mobility, which have received limited attention in the literature about peoples of Latino heritage in the United States, should be given increased consideration.

DISCUSSION

Analysis of HOS scores by sociocultural characteristics indicates that selected aspects of the experiences of the Latino immigrants merit attention; namely, length of settlement, health status, respondents' sex, marital status and household composition, educational levels, and occupational satisfaction.

1. *Community and School populations and levels of stress.* More than four times as many respondents in the community sample of recent immigrants as in the settled school parent group were rated as in the high stress level. Twice as many community respondents were in the intermediate stress level. These differing responses are highly pertinent, because they draw our attention to a critical factor about the adaptation of Latinos to urban environments which should be of special interest to researchers and practitioners. It seems important to emphasize, nevertheless, that the impairing impact of recent entry needs to be understood along with *specific* sociocultural variables which contribute to the emergence of psychiatric disorder as discussed below.

2. *Illness and Levels of Stress.* As expected, respondents with a reported health problem had a higher level of stress than those who were not experiencing such a problem. A finding of special interest with regard to the use of health services was that middle and high stress respondents of both the school and community groups were active users of medical resources for the resolution of somatic problems, as well as for complaints identified as "nerves." These findings merit attention in relation to available literature about the underrepresentation of some

Latino populations in mental health facilities. More detailed examination of the life styles and concerns about health of the higher-scoring respondents show that typically they do not seek professional mental health services for their crises. Nevertheless they recognize symptoms of psychological distress, and these are expressed to their significant others or to representatives of the professional medical system, particularly to private physicians. These findings are similar to the Karno and Edgerton data for the Mexican Americans in East Los Angeles, which showed that family physicians appeared to provide a "psychiatric receiving and sustaining service."[18]

The East Los Angeles findings raise some questions of possible pertinence to this investigation. In the study of a random group of physicians with offices in this California area, the authors learned that the recognition of emotional disorders and forms of treatment varied greatly among the physicians. These investigators did not discover any other formal resource in the community which was nearly so active and available a source of support for the emotionally disturbed Mexican American.[19] It may be that the tendency for Latinos in the present research to express symptoms of psychological distress in "general health" rather than in specialized "mental health" terms is associated with their tradition and reinforced by the presence of general physicians as the most available resources for symptoms of disease as well as symptoms which could be attributed to stress.

3. *Respondents' sex, marital status, and household composition.* The study of levels of stress by these characteristics should receive further examination in a larger population. This idea is supported by the following findings:

a. Although the overall mean scores for men and women were quite similar, there appear to be differences linked with length of residence in Washington and with household organization. Males in the community group who scored higher than men in the school parent group had spent a shorter period in this country. They lacked the support of spouse and children and experienced concerns associated with their unsettled status in this country. The women with similar characteristics appear to cope more successfully with these circumstances.

b. The childless never married, who by and large were the more highly educated men and women of the study, had a mean score indicating higher stress than the married, the previously married, or never married *parents*. Most were underemployed. In addition, they did not show the strong sense of purpose exhibited by those with spouse or children, who tolerated difficult conditions in order to attain desired improvements for children, a spouse, or kin.

c. Investigations of differences in level of stress by respondents' sex must give increased consideration to the impact of differences in the career paths of Latino men and women on their lives as parents or spouses. While Latino men seldom serve as single-parent heads of household, this path was followed by 60 percent of the women in the study who had entered the phase of parenthood. So far as I know, these aspects of social organization have received very limited attention in the literature on stress and its management among populations of Latin American origin.

Literature on Latino mental health points to the supportive functions of the family for the containment and management of psychological disorder.[20] Research on life changes and susceptibility to illness suggests also that solidarity in a family which faces change helps members to cope with stress more successfully than can those with only limited degrees of sharing.[21] The present study supports these findings. The data emphasize the critical importance, however, of understanding similarities and differences of ways in which Latino men and women cope with stress and use mutual support as parents, spouses, or adults without children.

4. *Educational levels and occupational satisfaction.* The fact that persons with the least education (representing largely community parents), as well as those with most advanced schooling (representing largely school parents), experienced greater stress than the mid-level group underscores the need to direct attention to the study of work and the adaptive patterns of disadvantaged groups. This receives support from findings in the Stirling County study and in North Carolina. In Stirling County, stress levels fell as education increased, up to and through high school. The lowest risk of such disorder for both men and women occurred among persons with eleven or twelve years of schooling. But the risk rose again with additional education.[22] In research which used the HOS among patients of public health nurses in North Carolina, the same trend was observed for Blacks through grade twelve, following which there was a steep increase in HOS scores among those with further education. The authors suggest that these Blacks may have been unable to apply such education, and this may have led to frustration.[23]

Among the Latinos in this research there are trends somewhat similar to the studies cited above. These patterns of response by the polar educational groups should direct attention to the impact of education and of occupational opportunity on the mental health of the members of disadvantaged groups. If, for example, Latinos and Blacks with high educational achievement experience stress associated with blocked mobility, mental health experts should recognize the importance of the problems which face such individuals in their efforts to enter the occupational mainstream of American society. Attention should turn also to the impairing symptoms experienced by most Latino men and women in unskilled occupations, who are acutely aware of the limitations of their jobs as compared to their own ability and experience marked difficulties in efforts to improve their employment levels.

5. *Use of the HOS among Latin American groups.* In the introduction to this chapter, reference was made to the limited data available on either treated or untreated psychiatric disorder among Latinos in the United States. The present study indicates that the HOS is a useful instrument to help identify characteristics that are associated with high or low levels of stress among members of this minority. With appropriate training and field supervision, the instrument can be readily administered by sensitive interviewers. It should be administered in the language in which respondents have the greatest facility.

A more extensive use of the HOS should offer a basis for definitive analysis of characteristic patterns of stress symptoms for this cultural group, for comparison with other populations among whom the HOS has beer used.

Interpretations of scores appear to be particularly meaningful when accompanied by complementary ethnographic study of the sociocultural environment in which respondents live and work.

CHAPTER 8

CONTROLARSE AND THE PROBLEMS OF LIFE

This chapter concentrates on the theme of *controlarse* (control of the self) and on mechanisms used by Latinos to deal with symptoms of anger, anxiety, and depression. The theme is discussed through focus on two major areas which were cited by respondents as sources of concern: (1) the behavioral problems of school children; and (2) conflict between men and women in conjugal relationships.

Controlarse is a central`mechanism for the regulation of behavior. It enables a Latino to exercise discipline over unpleasant feelings, thoughts, and moods. Through control of the self, Latinos keep in check negative feelings associated with unpleasant events *(disgustos)* or troubles and upsetting situations *(contrariedades)*. *Controlarse* helps to hold back outbursts of feeling such as anger *(corajes, enojos,* or *rabias)* or the reactions of fear which result from such unexpected experiences as *susto*, the "magical fright" described in Chapter 2.

Animo decaído (low spirits) is one of the frequent first indicators of depression. The persistence of depressed feelings leads to states of sorrow *(pena)*, suffering *(sufrimiento)*, and feelings of being disgraced *(desgracia)*. Descriptions of the suffering woman *(mujer sufrida)* or the disgraced man *(hombre desgraciado)* refer to those who have met with sorrow-laden events. Although a Latino may receive the sympathy of friends and family for the unfortunate events which he has met, he is expected to exercise control of his feelings and to raise his spirits.

Control of one's emotions and moods leads to various states such as *resignarse* (to resign oneself), *no pensar* (not to think: in this context, to avoid thinking of a problem), or *sobreponerse* (to overcome oneself). Resignation reflects acceptance of a sorrowful event and consent to fate, while *no pensar* refers to the avoidance of confrontation and the desire to suppress disturbing thoughts and feelings. *Sobreponerse* is the effort to overcome reactions to stress-conducive situations; it represents a Latino's willingness to confront a problem and a desire to alter his reactions to disturbance.

In the process of socializing their sons and daughters, Latino parents place priority on teaching children proper conduct through emphasis on the containment of feelings. Girls, for instance, who have to learn how to elicit respect and to maintain proper distance in interpersonal relations with boys, should govern their general demeanor by their ability to suppress their feelings. The belief that boys tend to express aggression overtly leads, likewise, to emphasis on the exercise of moderation in the display of aggression.

Men and women in conjugal relations emphasize the avoidance of a direct expression of conflict. This ideal is attained through a mutually shared belief that, when interpersonal conflicts occur, they should avoid the overt expression of negative feelings. A Latino who loses control of his ability to govern disturbing thoughts, feelings, and moods frequently reports changes in personality which are described as modifications in *caracter* (character). For example, men who experience an increasing difficulty in controlling their feelings of anger *(enojo)* over unpleasant situations note that, as a result, their character has changed *(tengo el caracter alterado)*. Women who feel that they are unable to restrain their anxiety speak also of changes in *caracter*. Some women believe that the use of birth control pills is harmful to their character *(caracter dañado)*.

The dynamic aspects of these concepts can be understood by giving careful attention to the common, as well as to the contrasting, expectations of the feminine and masculine ideals of *controlarse*, as illustrated in the following cases.

CONTROLARSE AND THE BEHAVIOR PROBLEMS AMONG CHILDREN

Descriptions of the behavior problems of children who live with their parents in Washington offer insights into the ideal roles for which they are being socialized.

Problems of concern to parents reflect the cultural expectations of behavior for adult men and women which are linked to the concepts of containment and control of negative sentiments. Contrasts between boys and girls are noted in the sex role expectations about proper conduct and the regulation of behavior.

In rearing girls of elementary school age, parents express a central concern with providing an environment that nurtures an appreciation for the value of *respeto* (respect). In recognition of this ideal, girls are required to maintain proper distance and control of self in relation to boys. *Respeto* becomes a major behavioral dynamic upon attainment of full adolescence and adulthood, as noted in the following case of Estela Leon's daughter, Margarita.

Estela was one of the mothers who worked overtime, as described in Chapter 4. The household consisted of Estela, her three daughters, a grandson, and a female cousin. Estela's physician had told her that at 205 pounds she was overweight and endangering her health. She and her two older daughters (who were in their early twenties) had started diets and had become increasingly conscious of the need to abstain from tempting foods. During a visit to Estela's home, Margarita, her fourteen-year-old daughter, asked me if she might partake in the diet counselling program. She explained that at school she had trouble seeing the writing on the blackboard; her vision was blurred, and she had headaches. To overcome this, she had moved to a desk which was close to the front of the room. She noted, however, that perhaps she also needed a diet because she had begun to eat more than usual at school, hoping that food would take the headaches away. The main point is, however, that Margarita spoke to me rather proudly of the fact that she had "no other problems." She compared herself to the young teenagers in their apartment building, noting that she avoided them because the girls, in particular, did not know how to make boys respect them, especially during various games which involved physical contact. Although she had developed good friends at school, she disliked her peers in the apartment building. These neighborhood children teased her and nicknamed her "saint" *(santa)* while she described their games as an orgy *(un relajo)*.*

Concern about the maintenance of an environment which would nurture *respeto* led parents to focus on this behavioral dimension, while placing lower priority on problems which school teachers viewed as more important

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*The variety of behavioral referents associated with the noun *relajo* is illustrated in the article by A. Lauria, Jr., "'Respeto,' 'Relajo,' and Inter-Personal Relations in Puerto Rico," *Anthropological Quarterly*, XXXVII, April 1964, pp. 53-67.

for educational performance. This is illustrated by the case of Blanca Jimenez, a ten-year-old girl.

Blanca's mother, Olga Jimenez, was called by her daughter's teacher to discuss reports that Blanca was "not studying." Schoolteachers felt that the girl's increasing loss of interest in her studies should be treated in a mental health center. Her problem had been brought to the attention of a school counsellor who had, in turn, referred Blanca and her parents to the center. At the time of this research, however, Olga had not taken her there. She was more preoccupied with the effects of the family's living conditions on Blanca than she was with her failing school record. She felt that the apartment where they lived was "too closed in" for a youngster, especially since the manager did not allow children to play in the hallways. Moreover, Olga was deeply worried because she had heard that at Blanca's school there were a number of male students who had not been brought up to "respect" girls. Consequently, she was seriously considering the possibility of sending Blanca to a boarding school where, she believed, Blanca would not only be protected but would also have more companionship. She and her husband would have to "work and sacrifice" to send her to a "good school" which she defined as being one with teachers who are concerned over the proper behavior of boys and girls to each other. Olga had become so worried over Blanca that whenever she spoke of her she experienced the onset of headaches and increased nervousness.

Parents reported that their sons presented a different set of problems from that of their daughters. Undesirable behavior for boys included rebelliousness *(conducta rebelde)*, lack of discipline *(indisciplinado)*, a tendency to fight *(peleon)* and nervousness or excitability *(nervios)*. The etiology of these problems was sometimes ascribed to physical dysfunction such as weak blood and head injuries or to heredity. At other times, it was linked to the influence of an estranged parent or a relative.

The types of problems described in the following excerpts offer perspectives on the parental views regarding the nature and management of boys' behavior difficulties.

Four years prior to the study, Hilda Molina, a single mother, had brought her only son, Roberto, to the States. They lived with her sister and her sister's husband. At the time of this research, she was worried because at age nine Roberto was repeating the second grade. He could read neither Spanish nor English, and she had been called to talk with the school personnel who wanted to help Roberto. She wondered whether he suffered from some form of congenital retardation or whether his behavior had resulted from a sharp blow on the head which he had received from playmates in the first year after their arrival in Washington.

Hilda had concerns about his nervous mannerisms and his *rebeldía* (rebelliousness) towards her. She had taken Roberto for examinations and tests in several well-known children's health centers in the city and he had been treated mainly for allergies. The school counsellors had referred him to a local psychiatric center, but at the time of the study he was no longer in active treatment at this facility.

Throughout their contact with health centers and mental health resources, Hilda and her relatives had hoped that someone would prescribe the correct tonics and foods to fortify her son. The family believed that with good physical health, defined mainly as a strong "constitution" and the prevention of weak blood, he would control his rebelliousness and improve his learning.

The "excitability" of nine-year-old Fernando was described by his mother, Matilde Rojas. Fernando suffered from nervousness, especially when he felt *emocionado* (highly moved). He also liked to shake while looking at himself in the mirror. When he began to fight with other boys, his mother had decided to change him to a different school, and she moved to a new apartment building. She viewed these changes as positive steps, since he appeared to have better control of his nerves and his grades also improved. Matilde was pleased with the principal in the new setting because she organized special recreation activities for the children outside of school, such as visits to the countryside. This was a welcome distraction, since the boy otherwise usually stayed in the apartment. Moreover, the mother felt that in the new building there were more desirable playmates for the child. She also believed it to be more secure. Actually she had spent many years in the other building before moving, but after she had been robbed and stabbed, she decided to make the change. Her son pointed out to me that his mother still had fears, since she had installed empty cans over the windows to make a noise in case someone broke into the apartment.

Matilde gave Fernando "One-a-Day" vitamins, *Emulsion Scott* (Scott's Emulsion, a tonic) and St. Joseph's Aspirin, as she thought they were needed. She had taken him to the local children's hospital where he was subjected to "all of the tests." He had also been seen at three different special counselling agencies with the recommendation that mother and son should participate in various programs.

Matilde had made contacts with these agencies, but at the time of this research, she was actively worried about the effect on children of the insecurity and lack of safety in the city. She sometimes dreamed of returning to her home country to live near her 32-year-old married son, but she realized that this was unrealistic, inasmuch as he had a wife and four children to support. Two years prior to the research the son had been forced to quit his job as a bus driver because of a health problem described as a "bad aorta," which was believed to cause his blackouts and fainting spells. He had been attacked and mugged by four men in a bar, and one of these men was reported to have kicked him in the area of the heart. The son had now become a fruit vendor, which gave him very limited income for his family. Consequently, Matilde had decided to resign herself to life as it was in Washington, with all its fears. At the time of this research, she felt increasing optimism due to her pleasure about Fernando's new school and his apparent loss of the symptoms of "excitability."

Descriptions of the behavior problems of these elementary school age students point to several aspects about the nature and management of conflicts. Parents hope that their children will develop the desired ability to exercise control and containment of certain negative feelings. Marked differences are evident, nevertheless, in the behavioral expectations for boys and girls. Feminine ideals about the protection of sexual sanctity (woman's source of honor) call for the early insistence on conduct to prepare girls to elicit respect and deference. The cultivation of these qualities requires training in self-containment, particularly in the presence of males. The discipline of boys, in contrast to that of girls, is centered to a much greater extent on the containment of the overt expression of aggression.

Differences between the views of parents and those of school authorities about the nature and management of problems were noted in the cases of Blanca Jimenez and Roberto Molina. Their parents, like other immigrants in the study, emphasized the supposed links between physical symptoms of weakness or hereditary defects and the behavioral problems of children. They hoped that nervousness and deficiency in school would be outgrown as their children attained optimal levels of physical health, measured in particular, by "strong blood." Schoolteachers, who had greater concern with educational performance and achievement, frequently referred such children to community resources. Parents reported that they had taken their boys and girls to specialists such as psychologists, psychiatrists, social workers, school counsellors, the local children's hospital, and a neurologist. At the time of this research, some parents were using school counsellors for crises but made only limited use of other agencies or mental health specialists.

Another area of marked parental preoccupation was the social quality of the neighborhood environment and its influence on their children. There was much discussion of the undesirable aspects of various places of residence and of threats of bodily harm or violence. A greater concern regarding the protection of children than is usually found in Latin American communities was based on the reality that immigrants or their close friends had been the victims of numerous robberies or assaults.*

In the cases described above, the parents engaged in considerable discussion about the negative effect of some aspect of apartment living on their lives. Hilda Molina was the only parent who did not immediately describe these preoccupations. Nevertheless, as I departed from my first visit to her apartment, I noted a chained and padlocked door which led to the kitchen. Hilda told me that this was the door through which burglars had entered the apartment a few days before my visit. She also mentioned that, a few months previously, the "health people" (representatives of the Health Department) had come to explain that the paint in her apartment was "poisoned." Although the "health people" had told her that the apartment owners would carry out certain required repairs and improvements of the building, the owners had not complied.

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*Fifteen respondents were known to have been victims of purse-snatchings, muggings, or apartment robberies. Other respondents had fears based on similar occurrences among kin and friends.

CONTROLARSE AND CONFLICT BETWEEN MEN AND WOMEN

Adults who have marriage problems are expected to try as much as possible to guard against expressing negative sentiments and to keep in check feelings of hostility towards a mate.

A leading source of stress between spouses is the contrast between feminine and masculine concepts of the nature and exercise of containment of feelings and control of the self. On the one hand, women are expected to act as moderators in tense situations and to contain emotions such as hostility to a greater extent than men. Following cultural tradition, woman's behavior is supposed to bring stability to a conjugal relationship. On the other hand, the practice of control of the self among men calls for the governing of strong feelings such as those associated with the expression of anger. Men are expected, however, to depend not only on their own control but also on the moderating influence of women. An aspect of strength in women's *caracter* is thus based on independent self-mastery and energy left over to help men, while masculine control of the self is to some extent dependent on the influence of women.

I have found, however, that among women these concepts of sex role relations are in a state of change. For instance, Juana Quesada indicated that drinking in itself was not the only source of her husband Melchor's diminished control of himself and of his shifting moods. She felt that he had other personal problems which required attention.

Juana and her husband expressed contrasting views about his emotional outbursts. Juana was much troubled by his frequent fits of temper, but he indicated that his loss of control took place only when he drank too much beer. Juana labeled her husband as neurotic and felt that something was the matter with his nervous system, but Melchor insisted that alcohol was the only explanation for his frequent bouts of anger. Their contrasting views were becoming a source of stress in their marriage, although they both contained their feelings to a degree and tensions surfaced mostly during his drinking episodes. At the time of this study, Juana was increasingly concerned about Melchor's view of his problem, particularly because his marked shifts in mood and irascibility were not limited to the periods when he drank beer.

To cite another instance, Lucía Díaz was a woman whose husband expected her to show control over her disdisturbed emotions. She feared increasingly, nevertheless, that she would not be able to cope with her anxiety and depression.

Lucía did not share her husband's view that she had to assume the major responsibility for improvement of their marriage through the exercise of control over her troubled feelings. She and her husband, Tomás, had a number of fights concerning management of money, their relationships with relatives, and sexual incompatibility. One day, after a strong disagreement, he left her, and she felt as if the world had come to an end for her. When he came back after a few weeks, Lucía was happy even though she did not like his advice upon his return. He told her, for example, that she ought to "conquer herself" --she ought to avoid "thinking" (of their troubles). *(El me dijo que me debo sobreponer, que no debo pensar.)* But Lucía found it difficult to pursue this course. She sometimes wondered whether some day she would become as distraught as her mother, who had died in an "insane asylum." She consulted various physicians who prescribed medicines to calm her, but these medicines did not relieve the sense of sorrow *(pena)* and emotional strain *(sufrimiento moral)* experienced when she realized that her marriage might terminate in separation. She was feeling overwhelmed by the burdens of too much suffering and too much affliction *(mucho sufrimiento y tanta aflicción)*.

During the course of this research, Lucía developed a number of organic and psychological symptoms for which she consulted several general practitioners. Some treated her physical symptoms only, while others suggested that all her problems were psychological. These contrasting ways of dealing with her symptoms led her to doubt the power of professional medicine. She increased her participation in religious services and hoped that her rediscovered faith would serve as an anchor for the resolution of her problems. Moreover, a central preoccupation throughout this period was the role of fate and heredity in her illness. She was losing hope in her own ability to understand and to face her husband, and she was developing marked fears about the inevitability of following in her mother's footsteps.

Lucía was most distressed because she could not meet the cultural expectation that voluntary control over her feelings would resolve her conjugal difficulties. She could not heed her husband's advice that she avoid thinking of the problems. Shortly before the completion of this research, she took a heavy overdose of aspirin. After this suicidal gesture, she continued to search actively for advice among lay and scientific practitioners of medicine and various religious ministers and counsellors.

The exercise of control over unpleasant or negative feelings in order to face the difficulties of the surrounding world is a neglected dynamic aspect of behavior among Latinos which should be intensively studied. The present research shows that, as Latinos and Latinas have engaged in efforts to alter their life situations, they have overcome difficulties through this mechanism. In the traditional manner, boys and girls are expected to learn to face temptations and problems simply through control over their disturbing feelings and thoughts. It should be noted, however, that the attainment of this behavioral ideal is seen as dependent, in part, on the maintenance of good health. A strong and healthy body is believed to be the foundation for the proper regulation of behavior.

In her recent pioneering work, *Vulnerability, Coping, and Growth*, Lois B. Murphy shows that the study of patterns of resilience and coping styles among children offers valuable insights about the strengths and resources of children.[1] Her own investigations have been conducted in a group from one ecological setting. Since there is little information on the patterns of child development and growth among Latinos in the United States, this area should receive high priority.

As to conjugal relationships, tension and contradictions often are resolved through mutually shared expectations about masculine and feminine forms of containment. Serious strains occur, however, when husband and wife have different ideas about the reasons for their inability to govern their disturbed sentiments. Changing concepts of role relations between the sexes accentuate these problems.

A number of researchers have characterized Latin Americans as persons who are passive endurers of stress[2] and tend to avoid direct interpersonal conflict. Latinos are said to bear disease and troubles through denial, courage, and acceptance. Studies conducted by Díaz-Guerrero among people of Mexican heritage, for example, show that the passive endurance of illness and stress is considered a virtue sustained by values such as harmony, protection, dependence, formality, and cooperation. Self-sacrifice is expected in all members of the family, together with submission, dependence, politeness, courtesy, and *aguante* (the ability to hold up well even in the face of abuse).[3]

This fatalistic view is linked with broader orientations towards life, as noted in Julian Samora's discussion of the concepts of health and disease among Spanish Americans in the Southwestern United States.

> Through original sin man's nature is basically evil; the process of living one's life, then, is always difficult because hardships and sufferings are the destiny of man. The reward, if there is to be any, for living this life is to be found not on this earth, which is a temporal existence, but in an eternal existence. To obtain this reward, one must save one's immortal soul. One can do this by changing one's basically evil nature to a nature which is basically

> good. Such a change is brought about by following God's commandments; by subjecting one's life to His will; by a personal love for God ... which transcends all love.[4]

Studies of conflict resolution in Latin American cultures often emphasize the dynamics of resignation and conformity, rather than control of the self and mastery over difficult circumstances. Resignation is, however, only one of the behaviors which can result from an ideal that leads to containment and suppression of feelings. *Controlarse* has two complementary dimensions. Latinos can contain their feelings and *either* resign themselves to their unkind fate *or* strive to overcome stress-inducing situations. Among the immigrants in this study, there was emphasis on the practice of *sobreponerse*, the ability to conquer and overcome one's disturbing feelings. The "problem cases" described in this chapter highlight conditions under which this ideal is difficult to achieve.

Future studies of childhood and adult socialization of members of these cultures should examine the modes through which they use this mechanism to attain desirable goals and objectives within the family group as well as in their relations to the larger society. Attention should also be given to devising ways in which these methods could be constructively altered to meet the requirements of new and different social patterns, both in the home country and in areas of resettlement.

CHAPTER 9

LATIN AMERICAN IMMIGRANTS TRANSFORM SOCIETY

Immigrants have transformed American society. In the course of settlement each newcomer group has shown a distinctive cultural character which reflects the conditions and experiences of the period of entry. This research on the movement of women and men from Latin America to the United States in the 1960s and 1970s has emphasized the other side of the coin; namely, the sociocultural realities which shaped the course of the immigrants' lives within the family, at work, and in the management of problems of illness and the stresses of life after entry. My purpose in this final chapter is to summarize major findings and to present implications of these findings for an understanding of Latino life both in the home countries and in the United States.

Most of the Latinas and Latinos in this study came to the United States to improve the family's socioeconomic status. They entered with the belief that self-sacrifice was necessary to achieve these goals and, in particular, the future welfare of their children.

Separation from home, however, was not the first major life hurdle which an immigrant had faced. The immigrant had learned that throughout life there are problems of one kind or another. Success consists in a willingness to face each problem and to overcome it.

Planning for the future and hard work were central values which enabled these immigrants to master the series of steps involved in immigration and settlement. The containment of feeling was also important. Through the practice of *controlarse* and *sobreponerse*, the Latinos coped with stress-inducing situations. Thus, these respondents did not fit a prevalent North American stereotype that the peoples of Latin American heritage tend to conform passively to unkind fate. Instead, these immigrants contained their feelings, faced difficulties, and worked to master them.

Most of the ninety-seven men and women who participated in the study were from Central and South America. They represented the prevalent nationalities from these areas which are found in Washington. Almost three-fourths of the total population were women. This high proportion signals the trend for Central and South American women to act as leaders of the immigration from those countries to the United States. Their emergence is an important development in the relations between Latin America and the United States which should be given increased attention.

The most frequently cited motives for emigration from the place of origin were to improve general life conditions and their economic situations. Most women entered the country for the first time after they had begun to raise a family, leaving children behind in the care of mothers or other maternal kin. Latinas were highly motivated, however, to reunite their families as soon as possible. They worked full time, or, if only part time, they aspired to gain full-time employment. Because they were in general less well-educated than the men who emigrated -- reflecting the situation in most Latin American countries -- they tended to be employed as domestics or in such semiskilled jobs as dry cleaning operators.

Those who came with prearranged contracts were at a disadvantage because many of them feared to leave jobs, even though they experienced injustices at the hands of the employers, lest they lose their immigration status. Others, however, were bolder and, after seeking advice, moved on to what they considered better jobs which gave them greater occupational flexibility, even if not higher pay.

Almost all of the immigrants -- men as well as women -- depended on advice and support from relatives or friends who assisted them in adjusting to the new circumstances in the Washington area. None came here by the New York route of former immigrants. They arrived by air via Miami or, if they were undocumented entrants, crossed the border from Mexico.

Two populations, a community group and a school parent group, were chosen for certain comparisons. Seven-eighths of the community group had been in this country five years and less, and they had sought health care during a designated period of time. Of this group, nearly half were in the unsettled undocumented status which was believed to add to their feelings of insecurity or anxiety. In contrast, over half of the school parents had been in this country six years and over. Although the physical and mental health status of the school parents was unknown prior to the research, it was believed that, as established immigrants, they would have lower levels of stress than the community group.

Findings showed contrasts in the household organization, reported health problems, and mental health status of the two groups. These differences underscored the high-risk status of settlers during early stages of entry, as compared with that of established immigrants who lived with their families. Men in the school group lived in a nuclear or extended family which included the spouse and most of their children seventeen and under. Men in the community group, for the most part, were separated from their families, who had remained at home.

Women in the school group had most of their children seventeen and under with them, whereas community women tended to have left younger children in Latin America.

With regard to health problems, at the time of the study about 65 percent of the total population reported some type of health problem. This total included 79.2 percent of the community group who were in active contact with health and social agencies but only 51.0 percent of the school parents. As expected, the overall level of stress of persons with a health problem was higher than that of persons who reported that they were not experiencing a health problem.

FAMILY AND HOUSEHOLD ORGANIZATION

Nuclear and extended families, composed of blood relatives and kin by marriage and connected by ties of propinquity, functioned as sources of mutual help in such tasks as child care, looking for jobs, or counselling for problems of illness. These findings were of interest in the light of some literature which suggests that "familism" or close kinship attachments among Latinos act as deterrents to mobility and achievement. Mutual help in the family was an important cushioning force which helped the newcomers in this study to settle and to establish new roles in the host society. I believe that a key issue about propositions on the function of "kinship ties" among Latinos has been the dearth of concrete detailed analyses of the structure of Latino households and domestic units and their relation to mutual exchange and assistance.

The household structure of immigrant families reflected their life cycle stages and their length of settlement in this country. During the early period of entry, for example, immigrants tend to leave children under twelve in the home country usually under the care of a member of the mother's family. These patterns of caretaking solidify the child's kinship ties with the maternal line. Immigrants who are established in the United States, such as the group of school parents, tend to have their younger children with them. Most of these immigrants, both men and women, work full time outside the home. The network of caretakers for these younger children includes relatives, paid baby sitters, nursery schools, and daughters of elementary school age.

The study of patterns of child-keeping and its meaning for adults and their children should be an area of high priority in research. Clearly, the availability of kin or close friends in the sending communities makes it possible for the Latina to leave home for the United States. My findings suggest, furthermore, that the immigrant parent retains her role as the economic provider through the system of monthly remittances to her home.

There are several questions about the findings on substitute care-taking with theoretical and practical implications. My field work in two Latin American countries suggested that, for the maternal grandmother, the role of caretaker is not always easy to fulfill. Conflicting demands or multiple responsibilities experienced by these grandmothers make it difficult for some to assume substitute parent roles. Different types of migration and of household structure also influence the organization of child-keeping and the specific concerns of the substitute parent.

A Latina who enters the United States with secure possibilities for obtaining her immigrant visa and the subsequent residency papers for her husband and her children makes temporary child-keeping arrangements with her relatives back home. The time span for substitute care arrangements can be predicted with some certainty. In contrast, Latinas who are single parents and who enter as undocumented workers cannot easily establish a time period for the resettlement of their children left behind. Frustrated efforts to change the undocumented status may increase the anxiety of all members of a family. Thus, a grandmother who cares for the children of this type of immigrant may give evidence of the tensions involved in these cooperative ventures in migration through an increased intake of vitamins for her "weak" constitution and the purchase of over-the-counter tranquilizers for her increased attacks of "nerves."

A distinction which needs to be made in caretaking studies is the designation of the ages of children for which substitute care is provided. Esther Goody has emphasized the importance of this aspect, as noted in the following comments: "There are differences in nurturance requirements of infants and young children on the one hand and older children and adolescents on the other."[1] Goody points out that the rearing of the very young which she calls "nurturant fosterage" means providing food, care and early socialization in bodily and impulse controls. The older child requires food and shelter but caretakers have the primary tasks of training in adult role skills and societal values.[2] Some of the problems which grandmothers at home experienced in caring for the children of immigrants may have been associated with the demands of children at certain ages of the life cycle. Efforts to assess the impact of substitute caretaking upon the children left behind, upon substitute caretakers, and upon the immigrant mothers should include these life cycle realities.

With regard to the composition of the immigrant families in the United States, there were unexpected data regarding the structure of households. The extended family was characteristic largely of the households headed by women. This is a finding of special interest, since some literature on the Latino family in the United States shows that extended kinship bonds are a source of emotional support and reciprocity. To the writer's knowledge, however, limited data are available on the dynamics of these reciprocal bonds in various kinds of single-parent households.

Nuclear families, composed of father, mother, and children, were characteristic largely of the settled school parent group. Connections with relatives who lived nearby, however, frequently served to strengthen affective ties as well as to exchange advice and services. Thus, these immigrants retain an interconnectedness with kin, but they tend to do so through external relationships in contiguous blocks and neighborhoods.

WORK AS A MICROCOSM OF U.S. SOCIETY

For both men and women immigrants, work was the avenue through which they came in contact with conditions in the United States that shaped their aspirations and identity. Those who came with prearranged jobs believed they were filling shortages in the labor market and entered the country with the approval of immigration authorities. Those who came without a specific job often had to lower their aspirations, but willingness to learn "on the spot" and to work over and beyond the expected minimum enhanced their employment potential. Some of these workers believed, however, that the reputed endurance of Latinos for hard work received only limited reward and little public recognition. It seemed to them as if, in taking the lowest-ranking jobs, which were no longer filled by low-income Anglos or Blacks, Latinos were being subjected to the negative attitudes previously shown to other minorities.

For most immigrants low-status work did not entail simply an evaluation of their knowledge and skills against the requirements of specific jobs. Work was the avenue through which they established key relations with representatives of the larger society. And it was on the job that they learned how *buen trato* and *mal trato* function in American society. On the one hand, through *buen trato* employers accorded Latinos personal dignity, a value through which the worth of the person was recognized, regardless of the type of job performed. *Buen trato* also established reciprocity and assistance for other problems of life. It helped to convert the ties of worker-employer relations into dynamic sources of assistance, advice, and protection. Through experiences with *mal trato* at work, on the other hand, Latinos were faced with the reality that in their host country differences in social status are clearly visible by socio-economic categories, by sex, and by ethnic membership.

They viewed each one of these discrete categories as a source of potential difficulty.

An example of these differences was seen in findings which showed that the occupational experience and career mobility of men and women differed. The Latinas were underemployed to a greater degree than men, and their average salaries were lower. Opportunities for women to gain new knowledge and skills for occupational advancement were further limited by their responsibilities for the household, care of children, or concern about the welfare of husbands or other adults.

HEALTH PROBLEMS, PRACTITIONERS, AND CROSS-CULTURAL COMMUNICATION

The health problems most commonly reported by Latin Americans in this study were musculoskeletal difficulties, gynecological complaints, gastrointestinal disorders, and nervous symptoms. A higher proportion of women than men reported health problems. On the other hand, women had a greater tendency than men to remain on the job in spite of illness. It was my impression that the absence of insurance coverage and sick leave benefits in a number of the settings where the respondents in this study were employed -- e.g., private homes and office buildings -- led individuals to make fewer visits to the physician than they needed, and to neglect followup visits for diagnostic work-ups or treatment.

Nevertheless, immigrants sought aid for their health problems from many types of consultants and practitioners. Their choice of diagnostician was associated with the nature of their symptoms. Kin, friends, and employers in Washington offered a wide range of advice about health matters. Relatives and other specialists in their countries of origin were consulted, usually through the mail. Private physicians were by far the most frequently used resource from the professional health care system, while they had limited contact with public health personnel.

The fact that private physicians such as internists were by far the most frequently used resource from the professional care system, rather than public health personnel or community mental health center workers, has implications for research and strategies of prevention and planning. It has been generally recognized that the peoples of Latin American heritage view the problems of physical and mental health in an integrated framework. Consequently, they expect professionals to offer care to cope with their general well-being rather than to deal separately with mental health problems.

There is, nonetheless, limited knowledge available in Latin America itself or in the United States of ways in which physicians or other caregivers in professional medicine actually contribute to the resolution of the mental health problems of their Latino patients. Empirically based research on the patterns of practice of these professionals and their Latino patients should offer a basis upon which to develop programs of mental health prevention and treatment. This area is important since the recent *Report to the President from the President's Commission on Mental Health*[3] points to the gaps in qualified mental health specialists from minority groups. The *Report* gives limited attention, however, to the possible use of general practitioners of medicine as a mental health resource for minorities.

Pharmacists in Washington do not act as intermediaries for the Latinos who seek medical care. This contrasts with the practice followed in their home countries. Drugstore personnel in small towns or urban centers in Latin America whence these immigrants had come had been active sources of health advice. They had listened to the symptoms of clients and offered counsel about new remedies or the latest antibiotic, sedative, or contraceptive. In contrast, the Washington pharmacists worked largely behind counters and glass partitions and so were removed from direct contact with customers. Pharmacists clearly limited their activities to the preparation of prescriptions ordered by physicians.

This increased regulation and role specialization of the medical professions in the United States has inclined Latinos to use non-medical settings, such as the household, as central contexts within which to ask, to learn, and continually to reformulate their notions about illness, its prevention, and its treatment.

The respondents were active in self-diagnosis and treatment, in consultation with relatives and friends. For certain disorders, however, they consulted Spanish-speaking physicians in private practice. They generally sought medical treatment for disorders believed to be of the blood and heart, gynecological and genitourinary problems, and persistent digestive disorders. For other symptoms such as chronic headaches, muscular aches, and "nerves," they relied both on the suggestions of their network of friends and advisors, and on health care professionals. Since a good proportion of the respondents had annual incomes under $5,000 and few had any health insurance, their combined use of household curing and physicians may have been partly related to financial circumstances.

The study of interaction in outpatient clinics highlighted the dilemmas of cross-cultural communication between caregivers and Latinos who seek service. The case of Josefa Domínguez, in particular, as described in Chapter 5, suggested that the sociocultural knowledge required for effective delivery of medical services is not insured simply by the assignment of staff who speak the same language as a patient. Effective cross-cultural communication calls for practitioners to have knowledge about their own culture as well as the social and cultural patterns of patients in such areas as family organization, beliefs about health and illness, and concepts of the unknown. This knowledge, furthermore, needs to be linked with the *specific dynamics of action* in each incident of illness. Practitioners need to recognize, for example, that patients adapt their style of interaction to the forms which they believe health care personnel expect of them.

This does not mean, however, that patients comply with medical advice. Quite aside from financial considerations, unrecognized conflicts in role relations between patient and practitioner may contribute to a Latino's increased use of resources outside a medical care setting. Physicians who believe that their patients have unquestioning faith in their expertise may actually contribute to the tendency for these patients to change their prescribed medical regime. In Josefa's case, the physician's lack of attention to her concepts of illness led her to active use of advice and treatment in the household.

SYNDROMES OF ILLNESS AND POPULAR MEDICINE

Symptoms were the focal areas through which Latinos adapted or rejected knowledge about etiology, diagnosis, and treatment. Each incident of illness contributed to the recombination of new concepts with the old. Furthermore, in facing their symptoms, Latin women and men did not draw at random from the traditions of popular or modern medicine. The four categories selected for discussion in Chapter 6 showed that Latinos view the problems of health and illness as manifestations of closely linked physiological *and* behavioral disturbance. This central feature of the Latino theory of disease provided the conceptual structure by which the immigrants made judgments about a disease and choices about the selection of practitioners.

Behavioral concerns such as the nervousness of children or the low spirits of adults were conditions frequently attributed to disorders of the blood. "Weakness of the blood" (*debilidad de la sangre*), as indicated by pale color, sallow skin, or obvious loss of weight, was a major diagnostic indicator of behavioral distress. This perceived relationship of physical symptomatology and psychological strain is of special importance in understanding some of the problems involved in the Latino's use of professionals for mental health treatment. In the case of children, on the one hand, parents continue to search for the physical basis of psychological distresses, even when they contact mental health professionals who rely on behavioral theories for treatment. Respondents' consultation with general practitioners of medicine, on the other hand, may not always be satisfactory, since these physicians tend to confirm the presence of disorders of the blood through the evidence of laboratory examinations.

The linkage of strong emotional experiences with irregularity or disorder of the heart frequently showed how symptoms can be reinterpreted and reclassified without a fundamental change in underlying beliefs. For example, Latinas described the onset of *cólicos de aire* (colics caused by *aire*) with terminology of high blood pressure and nerves adopted from modern medicine. Nevertheless, they searched their minds for the sudden exposure to air which they believed had precipitated such symptoms. Others gained new knowledge about the relation of overweight and cholesterol levels to heart problems, but this information still accompanied old beliefs about the influence of the weather.

The frequently experienced gastrointestinal, liver, or genitourinary disorders were defined by drawing on the full repertory of knowledge from popular medicine. Old and new concepts of etiology were examined to establish their possible fit with symptoms. In attempts to cure commonplace symptoms associated with these syndromes of illness, medicines bought over the counter, as well as leftover prescriptions, were tested and shared. Newly arrived friends from the old country replenished supplies of antibiotics or other medicines which could be bought in Washington only with the sanction of physicians. Since anxiety, anger, or lustful desires were identified as contributing factors to some of these problems, a Latino's ability to control emotional outbursts and intense feelings was considered important for prevention.

Findings regarding such chronic problems as musculoskeletal disorders and symptoms of arthritis faced Latinos with the limitations of treatment in the popular traditions as well as in scientific medicine. To close such gaps, the hot/cold theory was used as a stable explanatory framework while they searched for new ways to relieve their distressing symptoms.

Latinos are not unique among the world's people in viewing symptoms of disease as manifestations of disturbance in bodily and emotional being. As Charles Hughes has indicated, widespread throughout the world are broadly defined conceptions which define disease as manifestation of disharmony in man's overall relation to the universe.[4] These conceptions contrast with cultures in which members separate health from mental well being and other aspects of life.

Questions regarding the continuity of the Latino immigrant's theory of disease in the United States have been part of the long-established research concerns of the anthropologist. Under conditions of culture contact and migration, researchers frequently undertake studies which highlight the persistence of old beliefs and the adoption of the new. Yet, some years ago, C. Hughes pointed to directions of present-day sociocultural change which should lead to alternative concerns in the study of the changing cultures of immigrants. This author indicated that in modern societies it is difficult to describe a "stable environment" to which the human organism adapts. In his words, "the environment conceived in information and image terms is now ineffably greater than has ever been the case in human history. And, with such information comes the presentation of alternative courses of action and the need for decision, for evaluation, for reconciliation of such possibilities."[5]

It seems important to point out, therefore, that newcomers such as the Latinos in this study have faced complex tasks of adaptation to the medical systems which surround them, since concepts of etiology, prevention and cure are undergoing rapid change. Under these circumstances, research should thus identify the patterns through which modification and reorganization of thoughts and beliefs take place. Systematic examination of case studies should contribute to an increased understanding of these phenomena.

The detailed study of specific syndromes of illness should lead students of Latino culture, as well as specialists from the health care fields, to identify the dynamics of change which have relevance for action. Latinas who adopt vocabulary from scientific medicine, for example, may still retain their underlying traditional concepts of diagnosis and treatment, a fact that may not be evident to the health care professionals, since both seem to share the same language. Other Latinas combine notions of diagnosis and treatment drawn from various medical traditions, as shown through the concepts and practices used in household curing. Some immigrants may not abandon traditional concepts such as the hot/cold theory. Adaptation to the new setting may call, however, for the identification of environments which are comparable to the settings left behind. Finally, careful attention should be given to the function of traditional belief systems, since these may offer an immigrant the explanations necessary to cope with chronic illnesses that are difficult to cure.

SOCIOCULTURAL FACTORS AND THE MEASUREMENT OF STRESS

Epidemiological investigation to identify the sociocultural factors which might be correlated with symptoms of stress showed that the lack of mediating support systems contributed to the presence of impairing symptoms. The four major factors associated with differences in levels of stress, as measured by scores on the Health Opinion Survey (HOS) described in Chapter 7, were membership in the community or school parent group, sex of the subject, household organization, and level of satisfaction with jobs.

Comparisons of the symptom levels of the community and school parent groups underscored the notion that the absence of active family relationships, which satisfy such basic needs as the giving and receiving of love, contributed to a greater psychological risk in the community group. The differences in the way men and women drew on this support, however, were important. The community men who had higher stress scores had spent a shorter period of time in the United States, and they were separated from wives and families. In contrast, the established men in the school parent group, who lived with wives and children, had the lowest HOS scores of all groups. The scores of women did not show these marked contrasts. Differences in sex role expectations and family careers were evident in these findings.

Latino women were expected to exercise greater emotional self-reliance than men. Latino men seldom remained as single parents, whereas many of the women who had become heads of households established linkages with the extended network of kin without reestablishing conjugal ties. Although women appeared to cope more successfully with some stresses than men, life in the household setting was never "too good" or "too bad" for them. To some degree, such an outlook on life enabled Latinas to tolerate stress more successfully than men.

Findings that those subjects who wanted to change occupations (two-thirds of the total working group) had higher HOS mean scores than those who were satisfied with their jobs are significant, particularly when examined along with data about the poorly and well educated. The occupationally dissatisfied and poorly educated experienced greater stress than persons in the middle ranges. Recent research on the mental health of Latinos in the United States has given limited attention to the risk factors of groups in the higher educational levels. The potential vulnerability of Latinos who are frustrated in their aspirations for the higher ranks or more fulfilling jobs has important consequences for them as they strive for recognition and creativity in their lives. A frustration in occupational aspirations results in a weakening of ties with employers and alienation from the institutions of work which usually act as central connecting links with the dominant society.

With regard to the use of helping resources by middle and high scoring respondents, many visited physicians and outpatient clinics, but none were actively in contact with formal mental health agencies. These findings point to the limited availability of such resources for Latinos, as well as the respondents' concepts of behavioral problems. Data in Chapters 5, 6, and 8 show that Latinos make close connections between cultural factors and organic and behavioral symptoms in their notions of etiology and in the patterns of management of illness. A question of critical concern for those interested in the prevention of mental health problems among Latinos is: Just how are disturbing behavioral symptoms described during consultation with such physicians as the general practitioner, internist, or gynecologist? When symptom patterns occur, Latinos may seek relief from a physician. As life progresses, however, the symptom patterns may persist and may be more and more easily aroused. Practitioners may offer symptomatic relief, but of course these symptoms will not disappear unless something happens about the stress-inducing situation.

CONTROLARSE AND COPING WITH STRESS

Control of the self (*controlarse*) was identified as a central mechanism for the regulation of behavior, since Latinos used it to cope with symptoms of anger, anxiety, and depression. This behavioral ideal is also important because Latinos believe that the maintenance of good health depends on it. A strong and healthy body is believed to be the foundation for the proper regulation of behavior. The dynamic aspects of this mediating mechanism were identified in case analyses which offered descriptions of the expectations about the management of behavioral problems among schoolchildren and the solving of conflicts between men and women in conjugal relationships.

In the process of socialization, parents emphasized feminine and masculine ideals about the containment of feelings. Girls were expected to learn to cultivate behavior which would elicit respect and deference, while boys were to learn to control aggression. Parents expected these qualities to receive as high priority in the school setting as in the home. Parents and teachers, however, had contrasting views about the etiology of the school problems of Latino children. Whereas school authorities relied on referrals to traditional mental health specialists for counseling, parents searched for ways to change the perceived detrimental influence of physical weakness, heredity, peer group influence, and the social quality of the neighborhood environment.

As the children learn from their parents, in particular, a question to which special consideration should be given is: What influence do the changing concepts of relations between Latino men and women have on the child's coping patterns?

The illustrative cases of the Quesada and Díaz couples (Chapter 8) suggest that at times of conflict women in roles as wives call into question traditional beliefs about the nature of aggressive feelings among men and the self-containment of troubles among women. These changing views among wives should have impact on their roles as mothers and on their expectations of how growing girls and boys should cope with the challenges in the new setting. Unfortunately, to my knowledge, there is little information on these patterns of child development and growth among Latinos in the United States. In light of the increased interest in understanding patterns of resilience and vulnerability among children in general, this area should receive high priority.

IMPLICATIONS OF KEY FINDINGS

In the preceding summary and throughout the book I have pointed to the major issues which emerged from this study. Several areas related to the study of occupational activity, sex roles, and systems of social support have implications for the conceptualization and measurement of sociocultural factors, illness, and psychiatric disorder. These subjects should have priority in future research.

The findings of this study emphasized comparisons and contrasts between the ways of life and response patterns of Latino men and women. The implications of these differences need to be assessed in future ongoing research. Some years ago, Ginzberg and his associates showed that the study of the work careers of men was infinitely "less complicated" than the study of women's careers. These authors felt that they could describe men's occupational life within the framework of a "few simple patterns." But the life styles of working women interacted with many other facets in their lives in households and as community members. Women made each decision with respect to their jobs as if it might have an even greater impact on their families than on their careers, just as actions with respect to their homes and children might have primary consequences in the job arena.[6]

Research on the careers of Latino men and women as members of families and as workers should increase our understanding of the processes of adult socialization. In studying the processes of change in adult life, for example, Becker and others suggest that the concept of *commitment* helps to explain consistent lines of activity in pursuit of desired objectives. In the course of a career, a person may learn and engage in different kinds of activities. Yet all are viewed by the person as serving him in pursuit of highly sought goals.[7]

Many Latinas appear to be continuously altering their role expectations in the family and at work, in order to do better for their children or loved ones. They master the challenges of new or unknown situations by engaging in risk-taking behavior. We need to understand in greater detail just how the processes of reshaping old beliefs and behaviors, the learning of new customs, and the creation of new patterns of living combine to become part of their continuously evolving feminine and masculine ideals.

In a recent article[8] I have emphasized the policy implications of the movement of Latin American women to the United States. The deliberations on Western hemisphere immigration policy in this country should demonstrate the need for active concern over the complexities of immigration and settlement for *both* women and men. It appears that Latinas usually enter this country as "dependents" (for example, as a spouse, as an immigrant's mother, or as a child). Many are not counted in the worker certification programs of the U.S. Department of Labor, and their impact on our economy is not adequately assessed. Yet, women who enter as the relatives of an immigrant as well as those who lead in resettlement are committed to activity in full-time work soon after their entry. This is highly significant, since they work for a salary to a greater extent than the Latinas left behind and women in the U.S. labor force.

There are several methodological issues involved in assessing the influence of sociocultural factors on psychiatric disorders among Latinos which should be subject to further investigation. The Health Opinion Survey should be used more extensively among Latino immigrants from such contrasting regions of the Americas as Mexico, the Caribbean, and the Andes, as well as immigrants from urban and rural settings. Whether or not the scoring levels in this instrument need to be modified for use among Latinos in general is a question which should be addressed in these investigations.

The present research suggests that epidemiological study of psychiatric disorders conducted among contrasting groups can offer basic data about levels of impairing symptoms which can highlight and differentiate important stressful conditions. Yet some of the crucial issues about the interpretation of findings and their concrete relevance for the planning and delivery of services should be addressed with the use of complementary research approaches. For example, critical considerations associated with the presence or absence of social support systems and with feminine and masculine patterns of resolving conflict were identified and described through case study research conducted over time. My own work as a practitioner as well as a participant in the life of the community offered a sense and feel of the daily problems of individuals and of community groups which clearly underscored the need for systematic examination.

At an interdisciplinary conference on women and their health held in 1974, Cynthia Nelson, an anthropologist, suggested that the way in which we think about health care not only influences the ways in which the sick are restored to health but also has ramifications in our research perspectives and strategies.[9] She underscored the need for researchers to grasp how participants in health care and healing systems do in fact construct reality. Nelson reflected her concerns in the following observations:

> Knowing how many women are smoking or drinking or suffering from what kind of diseases or how many, and who are utilizing what services, or who is delivering what to whom, does not provide us understanding of the kinds of stresses women live under and how women themselves define and cope with the stresses in their lives, or indeed what is even considered 'stressful . . .' In short, seeking healing is not merely a medical matter, but is a moral issue in which constructions of self and illness shape and are shaped by definer and defined, healer and healed, person and society. And it is to these issues that we should direct our research on women and their health.[10]

Future research on the physical and mental health of Latinas and Latinos should increasingly focus on aspects of their life situations that prevent or contribute to illness, and identify their perspectives on the forces which contribute to dissatisfaction, stress, and illness.

CONCLUDING COMMENTS

Immigrants are American history and the character of the movement of Latinos to urban centers in the United States is shaped and remolded by complex conditions. In the present research I have emphasized prevailing forms of social organization and the views of the Latinos themselves about their culture, symptoms of illness, and symptoms of stress. The Immigration and Nationality Act of 1965 is a landmark because priority is given to *what immigrants do* rather than to *who they are*. The emphasis is clearly on a preference for persons with skills and occupations which are not sufficiently available in the U.S. labor force. As an anthropologist, I have documented the experiences of Latin American immigrants and their families in the historic context of the labor imperatives which guide the relations between peoples. However, the record of the participants in this study should force us to consider the question of economics in a much broader context. We have to move from the demands of national policy to the study of specific processes and exchanges which characterize the immigrant condition.

NOTES

INTRODUCTION

[1] Oscar Handlin, *The Uprooted*, 1951.

[2] Victor Fuchs, *Who Shall Live?*, 1974.

[3] U.S. Department of Justice, Domestic Council on Illegal Aliens, *Preliminary Report*, 1976. Quoted passages are from pp. 18, 19, and 32-33.

CHAPTER 1

[1] R.N. Adams, *Cultural Surveys of Panama, Nicaragua, Guatemala, El Salvador, Honduras*, 1957; Adams and A.J. Rubel, "Sickness and Social Relations," 1967; M. Clark, *Health in the Mexican-American Culture*, 1959; G.M. Foster, "Relationships between Spanish and Spanish-American Folk Medicine," 1953; C. de Guevara, *Exploración Etnográfica en el Departamento de Santa Ana*, 1973; I. Kelly, *Santiago Tuxtla, Veracruz Culture and Health*, 1956; W. Madsen, *The Mexican-Americans of South Texas*, 1964; V.G. de Pineda, *La Medicina Popular en Colombia*, 1961; G. and A. Reichel-Dolmatoff, *The People of Aritama*, 1961; M. Richardson and B. Bode, *Popular Medicine in Puntarenas, Costa Rica: Urban and Societal Features*, 1971; A.J. Rubel, *Across the Tracks: Mexican-Americans in a Texas City*, 1966, and "Concepts of Disease in Mexican-American Culture, 1960; J. Samora, "Conceptions of Health and Disease among Spanish-Americans," 1961; L. Saunders, *Cultural Difference and Medical Care*, 1954; O.G. Simmons, "Popular and Modern Medicine in Mestizo Communities of Coastal Peru and Chile," 1955; H. Valdizán and A. Maldonado, *La Medicina Popular Peruana*, 1922.

[2] B.B. Berle, *80 Puerto Rican Families in New York City*, 1958; C. Hanson and L. Saunders, *Nurse-Patient Communication*, 1964; F.C. Nall and J. Speilberg, "Social and Cultural Factors in the Responses of Mexican-Americans to Medical Treatment," 1967; A. Ordoñez-Plaja *et al.*, "Communication between Physicians and Patients in Outpatient Clinics," 1968; I. Press, "Physicians, Curers and Dual Use in Bogotá," 1969; C.H. Teller, "Access to Medical Care of Migrants in a Honduran City," 1973.

[3] See however, E.B. Brody, *The Lost Ones*, 1973, and M. Argandoña and A. Kiev, *Mental Health in the Developing World*, 1972.

[4] E.G. Jaco, *The Social Epidemiology of Mental Disorders*, 1960, and "Mental Health of the Spanish-American in Texas," 1959; B. Malzberg, *Mental Disease among the Puerto Rican Population of New York State* 1960-1961, 1965; B.P. and B.S. Dohrenwend, *Social Status and Psychological Disorder: A Causal Inquiry*, 1969.

[5] A.H. Leighton, *My Name is Legion*, 1959; C.C. Hughes *et al.*, *People of Cove and Woodlot*, 1960; D.C. Leighton *et al.*, *The Character of Danger*, 1963.

[6] B.S. and B.P. Dohrenwend (eds.) *Stressful Life Events*, 1974; L. Levi (ed.) *Society, Stress and Disease*, 1971; L.E. Hinkle, Jr., "The Concept of 'Stress' in the Biological and Social Sciences," *Science, Medicine and Man*, 1973; H. Selye, *The Stress of Life*, 1956; A. Meyer, "Pathology of Mental Diseases," 1951, and "The Life Chart and the Obligation of Specifying Positive Data in Psychopathological Diagnosis," 1951.

[7] L.M. Cohen and C.L. Fernandez, "Ethnic Identity and Psychocultural Adaptation of Spanish-Speaking Families," 1974.

[8] Rita L. Ailinger, M.S.N., Ph.D., helped to conduct the interviews in the schools. Carmen L. Fernandez, M.S.W., conducted a group of interviews with domestic workers. I conducted most of the community interviews and part of the school research.

[9] For detailed discussion on the HOS consult A.M. Macmillan, *The Health Opinion Survey*, 1957, pp. 325-339, and D.C. Leighton *et al.*, *The Character of Danger*.

CHAPTER 2

[1] M. Pearsall, "Consensus and Conflict in Health Care Delivery: Some Anthropological Thoughts," 1973, p. 214.

[2] C.C. Hughes, "Health and Well-Being Values in the Perspective of Sociocultural Change," 1966, p. 130.

[3] *Ibid.*, p. 125.

[4] R.N. Adams and A.J. Rubel, "Sickness and Social Relations," 1967, pp. 333-355; E.B. Brody, *The Lost Ones*, pp. 503-589; R. Díaz-Guerrero, *Psychology of the Mexican*, 1967, pp. 3-20; G.M. Foster, "Relationships between Spanish and Spanish-American Folk Medicine," pp. 201-217; S. Iutaka, "Social Status and Illness in Urban Brazil," 1966, pp. 97-100; Pan American Health Organization, *Health Conditions in the Americas, 1969-1972*, 1974, pp. 3-27; R. Paredes Manrique (ed.), *Recursos Humanos para la Salud y la Educación Médica en Colombia*, 1968, pp. 59-75; D.K. Zschock, "Health Planning in Latin America: Review and Evaluation," 1970, pp. 35-56.

[5] J. Samora, "Conceptions of Health and Disease among Spanish-Americans," pp. 314-323.

[6] G. and A. Reichel-Dolmatoff, *The People of Aritama*, p. 333.

[7] Foster, "Relationships between Spanish and Spanish-American Folk Medicine," pp. 201-217; V.G. de Pineda, *La Medicina Popular en Colombia*, pp. 41-83; M. Richardson and B. Bode, *Popular Medicine in Puntarenas, Costa Rica: Urban and Societal Features*, pp. 251-261.

[8] Pineda, *La Medicina Popular*, p. 66.

[9] Iutaka, "Social Status and Illness," pp. 103-109; Pineda, *La Medicina Popular*, pp. 66-69; Reichel-Dolmatoff, *The People of Aritama*, p. 294; O.G. Simmons, "Popular and Modern Medicine in Mestizo Communities of Coastal Peru and Chile," pp. 66-69.

[10] L. Saunders, *Cultural Difference and Medical Care*, pp. 148-149.

[11] R.N. Adams, *Cultural Surveys of Panama, Nicaragua, Guatemala, El Salvador, Honduras*, pp. 478-485; 362-371; M. Clark, *Health in the Mexican-American Culture*, pp. 172-173, 207-212; C. de Guevara, *Exploración Etnográfica en el Departamento de Santa Ana*, pp. 41-42; G. and A. Reichel-Dolmatoff, "Nivel de Salud y Medicina Popular en una Aldea Mestiza Colombiana," 1958, p. 40; A.J. Rubel, "Concepts of Disease in Mexican-American Culture," pp. 800-805.

[12] R.L. Currier, "The Hot-Cold Syndrome and Symbolic Balance in Mexican and Spanish-American Folk Medicine," 1966, p. 251;

G.M. Foster and J.H. Rowe, "Suggestions for Field Recording of Information on the Hippocratic Classification of Diseases and Remedies," 1951, pp. 1-3; A. Harwood, "The Hot-Cold Theory of Disease," 1971, pp. 1153-1158; M.H. Logan, "Humoral Medicine in Guatemala and Peasant Acceptance of Modern Medicine," 1973, pp. 385-395; F. McFeely, "Some Aspects of Folk Curing in the American Southwest," 1957, pp. 95-110; W. Madsen, "Hot and Cold in the Universe of San Francisco Tecospa, Valley of Mexico," 1955, pp. 123-139.

[13] Adams and Rubel, "Sickness and Social Relations," pp. 338-340; Clark, *Health in the Mexican-American Culture*, pp. 164-170; Foster, "Relationships between Spanish and Spanish-American Folk Medicine," pp. 209-210; Simmons, "Popular and Modern Medicine in Mestizo Communities," pp. 60-62.

[14] R.N. Adams, *Cultural Surveys of Panama, Nicaragua, Guatemala, El Salvador, Honduras*, pp. 381, 481; Clark, *Health in the Mexican-American Culture*, pp. 170-172; Foster, "Relationships," pp. 210-211; Pineda, *La Medicina Popular en Colombia*, p. 57; Simmons, "Popular and Modern Medicine," pp. 60-62.

[15] Adams and Rubel, "Sickness and Social Relations," pp. 345-347; Foster, "Relationships," pp. 211, 216-217; Simmons, "Popular and Modern Medicine," pp. 61-62; Pineda, *La Medicina Popular*, pp. 56-57; Reichel-Dolmatoff, *The People of Aritama*, pp. 309-313, 332-336.

[16] Adams and Rubel, "Sickness and Social Relations," p. 345; Clark, *Health in the Mexican-American Culture*, pp. 175-176; I. Kelly, *Santiago Tuxtla, Veracruz Culture and Health*, p. 92.

[17] Richardson and Bode, *Popular Medicine in Puntarenas, Costa Rica*, p. 264.

[18] I. Kelly, *Folk Practices in North Mexico*, 1965, p. 82.

[19] J. Gillin, "Magical Fright," 1965, pp. 402-409; C.W. O'Nell, "An Investigation of Reported 'Fright' as a Factor in the Etiology of SUSTO, 'Magical Fright'," 1975, pp. 41-63; A.J. Rubel, "The Epidemiology of Folk Illness: Susto in Hispanic America," 1964, pp. 268-283; W.C. Sayres, "Status Transition and Magical Fright," 1955, pp. 292-300; O. Simmons, "Popular and Modern Medicine," pp. 61-62; D. Uzzell, "Susto Revisited: Illness as Strategic Role," 1974, pp. 369-378.

[20] Rubel and O'Nell, "The Meaning of Susto (Magical Fright)," 1974, p. 6.

[21] Pineda, *La Medicina Popular*, p. 57.

[22] *Ibid.*, pp. 41-83; Iutaka, "Social Status and Illness," pp. 102-109; I. Press, "Physicians, Curers and Dual Use in Bogotá," pp. 209-218.

[23] Simmons, "Popular and Modern Medicine," pp. 66-71.

[24] Richardson and Bode, *Popular Medicine in Puntarenas, Costa Rica*, p. 261.

[25] H. Fabrega, Jr., "Medical Anthropology," 1972, pp. 187-190.

[26] R. Firth, "Acculturation in Relation to Concepts of Health and Disease," 1971, pp. 153-154.

[27] A. Leighton, *My Name is Legion*, 1959; C.C. Hughes *et al.*, *People of Cove and Woodlot*, 1960; D. Leighton *et al.*, *The Character of Danger*, 1963; B. Kaplan (ed.) *Psychiatric Disorder and the Urban Environment*, 1971. Owing to frequent reference, these publications

will be cited hereinafter by title only.

[28] *My Name is Legion*, pp. 146-157.

[29] *Ibid.*, pp. 149-157.

[30] See *The Character of Danger* and Leo Srole *et al.*, *Mental Health in the Metropolis*, 1962; H. Selye, "The Evolution of the Stress Concept -- Stress and Cardiovascular Disease," 1971, pp. 299-311.

[31] *The Character of Danger*, pp. 357-365.

[32] A. Meyer, "Pathology of Mental Diseases," p. 297.

[33] *The Character of Danger*, pp. 3-29; E.M. Gruenberg, "Epidemiology of Mental Disorders," 1957, pp. 107-125; M. Kramer, "A Discussion of the Concept of Incidence and Prevalence as Related to Epidemiologic Studies of Mental Disorders," 1957, pp. 826-840.

[34] *My Name is Legion, People of Cove and Woodlot, The Character of Danger.*

[35] J. Myers *et al.*, "Social Class, Life Events, and Psychiatric Symptoms: A Longitudinal Study," 1974, pp. 192-205; Myers *et al.*, "Life Events and Psychiatric Impairment," 1971, pp. 149-157.

[36] M. Karno and R. Edgerton, "Perception of Mental Illness in a Mexican-American Community," 1969, pp. 233-238; R. Edgerton, M. Karno and I. Fernandez, "Curanderismo in the Metropolis," 1970, pp. 124-134; Karno *et al.*, "Mental Health Roles of Physicians in a Mexican-American Community," 1969, pp. 62-69.

[37] See note 34 above.

[38] *My Name is Legion*, p. 326.

[39] *The Character of Danger*, pp. 13-14.

[40] D.C. Leighton, "The Empirical Status of the Integration-Disintegration Hypothesis," 1971, pp. 77-78.

[41] *Ibid.*

[42] *People of Cove and Woodlot*, p. 213.

[43] *Ibid.*, p. 227.

[44] *The Character of Danger*, pp. 365-368.

[45] *People of Cove and Woodlot*, pp. 426-427.

[46] Myers *et al.*, "Social Class, Life Events, and Psychiatric Symptoms," 1974.

[47] The authors studied life events in terms of an evaluated dimension corresponding to social desirability. In terms of the "shared values of society" one group of events which was judged to be *desirable* included "graduation from school, moved to a better neighborhood, engagement, marriage, promotion in work, success at work, and improvement in financial status." The group of *undesirable* events included "failure in school, a move to a less desirable neighborhood, divorce, trouble with in-laws, serious injury or accident, death of a loved one, business failure, and detention in jail." Events which were considered ambiguous were those for which there was disagreement such as "pregnancy, entered armed forces, and retired from work" (Myers *et al.*, "Social Class," pp. 196-197).

B. Dohrenwend has built an index of the undesirability of events experienced by classifying events reported by respondents as culturally defined losses or gains or as ambiguous, according to the following definitions: "Loss: An event or change that other people would generally think undesirable. Gain: An event or change that other people would generally think desirable. Ambiguous: An event or change whose desirability is ambiguous because people probably disagree about its desirability or for lack of information about the event" ("Life Events as Stressors: A Methodological Inquiry," 1973, p. 170).

This author explains that the research literature reveals several different conceptions of the characteristics that make an event stressful. Some investigators use events which by general public consensus are likely to produce emotional disturbance in many people. Other conceptions concerned with stressful life events focus on change as a crucial factor or life change as stressful. ("Life Events as Stressors: A Methodological Inquiry," p. 168).

[48] The study of "life change" events follows the work of Holmes, Rahe, and their collaborators, which has established that a cluster of social events that requires change in ongoing adjustment, is significantly associated with the time of illness onset. The Social Readjustment Rating Scale developed by these investigators has been used to study recall of life events and to evaluate the relationship of life change to the occurrence of disease. These authors have found that in studying factors which make an event stressful, "a common theme is that at the occurrence of each event, some adaptive or coping behavior was evoked." (T.H. Holmes and R.H. Rahe, "The Social Readjustment Rating Scale," 1967, p. 217);

Holmes and Masuda, "Life Change and Illness Susceptibility," 1974, pp. 45-72; Rahe *et al.*, "Social Stress and Illness Onset," 1964, pp. 209-218).

Barbara Snell Dohrenwend states that "total exposure to stressful events is calculated by summing the readjustment scores of all events experienced by an individual in a given period of time. Individuals who experience events that yield higher total readjustment scores are more likely than individuals with lower total readjustment scores to become ill during a subsequent observation period. Among those who become ill, the ones with total scores suffer a larger number of illnesses" ("Life Events," pp. 168-169).

[49] Myers *et al.*, "Social Class," p. 202.

[50] J.K. Lindenthal *et al.*, "Psychological Status and the Perception of Primary and Secondary Support from the Social Milieu in Time and Crisis," 1971, pp. 92-98.

[51] *Ibid.*, p. 95.

[52] *Ibid.*, p. 97.

[53] In reviewing the Latino literature for purposes of this particular research, I selected material focused on the Mexican-Americans because their conditions of entry to the United States have had certain similarities to the situation of the respondents of this study. As U.S. nationals, Puerto Ricans do not face the problems of immigration status and ability to enter or leave the country which face the nationals of the foreign countries. The conditions faced by Cubans who have entered the country as refugees are recognized as unusual circumstances.

[54] E.G. Jaco, "Mental Health of the Spanish-American in Texas," pp. 467-485; W. Madsen, "Mexican-Americans and Anglo-Americans: A Comparative Study of Mental Health in Texas," 1969, pp. 217-240; H. Fabrega, Jr. *et al.*, "Ethnic Differences in Psychopathology I. Clinical Correlates under Varying Conditions," pp. 218-226; H. Fabrega, Jr., "Ethnic Differences in Psychopathology II. Specific Differences with Emphasis on a Mexican Group," pp. 221-235; Karno and Edgerton, "Perception of Mental Illness in a Mexican-American Community," pp. 233-238; C.W. Wignall and L. Koppin, "Mexican-American Usage of State Mental Hospital Facilities," 1967, pp. 137-148.

[55] Karno and Edgerton, "Perception of Mental Illness in a Mexican-American Community," 1969; Madsen, "Mexican-Americans and Anglo-Americans," 1969.

[56] Karno and Edgerton, "Perception of Mental Illness."

[57] E.G. Jaco, *The Social Epidemiology of Mental Disorders*, 1960, "Mental Health of the Spanish-American in Texas," 1959, and *Patients Resident by Ethnic Group -- Hospitals for the Mentally Ill*, Bulletin 45, California Department of Mental Hygiene Biostatistics Section, 1966, p. 21, as cited in Karno and Edgerton, "Perception of Mental Illness."

[58] Madsen, "Mexican-Americans and Anglo-Americans," pp. 238-240.

[59] Karno and Edgerton, "Perception of Mental Illness," pp. 236-237.

[60] Karno, Ross and Kaper, "Mental Health Roles of Physicians in a Mexican-American Community," 1969.

[61] Edgerton, Karno and Fernandez, "Curanderismo in the Metropolis," 1970.

[62] Edgerton and Karno, "Mexican-American Bilingualism and the Perception of Mental Illness," 1971, pp. 286-290.

[63] E. Leacock, "Three Social Variables and the Occurrence of Mental Disorder," 1957, pp. 308-337.

[64] R.S. Lazarus *et al.*, "The Psychology of Coping: Issues of Research and Assessment," 1974, pp. 259-263.

[65] Robert W. White, "Strategies of Adaptation: An Attempt at Systematic Description," 1974, p. 49.

[66] *Ibid.*, p. 52.

[67] W. Goldschmidt, "Ethology, Ecology, and Ethnological Realities," in George V. Coelho *et al.*, *Coping and Adaptation*, 1974, p. 23.

[68] R.J. Lifton, *History and Human Survival*, 1970, pp. 310-373; G. and L. Spindler, "Psychology in Anthropology: Applications to Culture Change," 1963, pp. 515-516.

CHAPTER 3

[1] U.S. Department of Justice, Immigration and Naturalization Service, 1973 *Annual Report*, 1974, p. 73.

[2] See L. Grebler *et al.*, *The Mexican-American People*, 1970, pp. 350-377.

[3] *Ibid.* For recent Latin American data, consult V.G. de Pineda, *Estructura Función y Cambio de la Familia en Colombia*, 1975, pp. 309-328.

CHAPTER 4

[1] A more detailed study of this group is found in Carmen L. Fernandez, "Socio-Cultural Factors in the Adaptation Process of Spanish-Speaking Domestic Workers Who Are Heads of Households," 1973, pp. 50-51.

[2] See E.C. Hughes, *Men and Their Work*, 1958, pp. 32-55; and L.A. Coser, "Servants: The Obsolescence of an Occupational Role," 1973, pp. 31-40.

CHAPTER 5

[1] R.N. Adams and A.J. Rubel, "Sickness and Social Relations," p. 334,

[2] See A. Ordoñez-Plaja *et al.*, "Communication between Physicians and Patients in Outpatient Clinics," pp. 161-213; and S. King, *Perceptions of Illness and Medical Practice*, 1962, pp. 227-231.

[3] M. Karno *et al.*, "Mental Health Roles of Physicians in a Mexican-American Community," pp. 62-69.

[4] R.L. Ailinger, "Illness Referral System of Latin American Immigrant Families," 1974, pp. 136-137.

[5] R.B. Edgerton, M. Karno and I. Fernandez, "Curanderismo in the Metropolis," pp. 124-134.

[6] The studies of Roemer, Teller and Iutaka, point to the continued high status of the private sector of medical care, despite the expansion of social security or other medical care programs (M.I. Roemer, "Medical Care and Social Class in Latin America," 1964,

pp. 54-64; C.H. Teller, "Access to Medical Care of Migrants in a Honduran City," pp. 214-226; S. Iutaka, "Social Status and Illness in Urban Brazil," pp. 102-109).

The problems of health care resources for a country such as Colombia are described by Dieter K. Zschock in his analysis of the Colombian Study on Health Manpower and Medical Education in Colombia: "Nine out of ten physicians practice in towns and cities, which account for one-third of the country's population. Very few municipal public health posts, which are the only source of modern medical care for most of the rural population, are permanently staffed by trained medical personnel. ("Health Planning in Latin America," pp. 35-56).

[7] U.S. House of Representatives, Subcommittee No. 1 of the Committee on the Judiciary, 1971.

[8] R.N. Wilson, "Patient-Practitioner Relationships," 1963, p. 283.

[9] E. Friedson, *Patients' View of Medical Practice*, 1961, p. 175.

CHAPTER 6

[1] V.G. de Pineda, *La Medicina Popular en Colombia*, pp. 54-55.

CHAPTER 7

[1] See A.H. Leighton, *My Name is Legion*, and D.C. Leighton *et al.*, *The Character of Danger*.

[2] A.M. Macmillan, *The Health Opinion Survey*, pp. 326-335; *The Character of Danger*, pp. 200-233; D.C. Leighton and N.F. Cline, "The Public Health Nurse as a Mental Health Resource," 1968, pp. 40-41.

[3] See particularly *My Name is Legion*, *The Character of Danger*, and C.C. Hughes *et al.*, *People of Cove and Woodlot*.

[4] Leighton and Cline, "The Public Health Nurse," pp. 40-42.

[5] *Ibid.*

[6] *My Name is Legion*, pp. 355-362; *The Character of Danger*, pp. 356-365.

[7] *My Name is Legion*, p. 356.

[8] *Ibid.*, p. 350.

[9] See A.H. Leighton *et al.*, *Psychiatric Disorder among the Yoruba*, 1963; S. Kellert *et al.*, "Culture Change and Stress in Rural Peru," 1967, pp. 391-415; D.C. Leighton and N.F. Cline, "The Public Health Nurse," pp. 36-53; J.J. Schwab *et al.*, "Social Psychiatric Impairment: Racial Comparisons," 1973, pp. 183-187.

[10] A.H. Leighton *et al.*, *Psychiatric Disorder among the Yoruba*, pp. 18-21.

[11] S. Kellert *et al.*, "Culture Change and Stress," pp. 391-396.

[12] L.H. Rogler and A.B. Hollingshead, *Trapped: Families and Schizophrenia*, 1965.

[13] Kellert *et al.*, "Culture Change and Stress," pp. 391-395.

[14] *Ibid.*, p. 394.

[15] *Ibid.*, pp. 396-415.

[16] *The Character of Danger*, pp. 253-279, 365-368.

[17] L. Srole *et al.*, *Mental Health in the Metropolis*, pp. 175-186.

[18] M. Karno *et al.*, "Mental Health Roles of Physicians in a Mexican-American Community," p. 68. See also Karno and Edgerton, "Perception of Mental Illness in a Mexican-American Community," pp. 233-238.

[19] Karno *et al.*, "Mental Health Roles," pp. 65-68.

[20] E. Jaco, "Mental Health of the Spanish-American in Texas," pp. 467-484; W. Madsen, "Mexican-Americans and Anglo-Americans: A Comparative Study of Mental Health in Texas," pp. 217-240; H. Fabrega, Jr., "Mexican-Americans of Texas: Some Social Psychiatric Features," 1970, pp. 249-273; Amado M. Padilla, Manuel L. Carlos and Susan E. Keefe, "Mental Health Service Utilization by Mexican Americans," 1976.

[21] *The Character of Danger*, pp. 322-353; C. Hughes *et al.*, *People of Cove and Woodlot*, pp. 392-433; J. Cassel, "Physical Illness in Response to Stress," 1970, pp. 189-207.

[22] *The Character of Danger*, pp. 296-299, 472-483.

[23] Leighton and Cline, "The Public Health Nurse," p. 44.

CHAPTER 8

[1] L.B. Murphy and A.E. Moriarty, *Vulnerability, Coping and Growth*, 1976, p. 351.

[2] G. and A. Reichel-Dolmatoff, *The People of Aritama*, 1961; R. Díaz-Guerrero, *Psychology of the Mexican*, 1967; W.H. Holtzman *et al.*, *Personality Development in Two Cultures*, 1975; J. Samora, "Conceptions of Health and Disease among Spanish-Americans," 1961; M. Clark, *Health in the Mexican-American Culture*, 1959; E.B. Brody, *The Lost Ones*, 1973.

[3] Díaz-Guerrero, *Psychology of the Mexican*, pp. 112-136.

[4] Samora, "Conceptions of Health and Disease," pp. 315-316.

CHAPTER 9

[1] Esther Goody, "Forms of Pro-Parenthood: The Sharing and Substitution of Parent Roles," in Jack Goody, *Kinship*, 1971, p. 335.

[2] *Ibid.*, pp. 331-345.

[3] *Report to the President from the President's Commission on Mental Health* 1978, Vol. I, 1978.

[4] C. Hughes, "Health and Well-Being Values in the Perspective of Sociocultural Change," pp. 129-130.

[5] *Ibid.*, p. 156.

[6] E. Ginzberg *et al.*, *Life Styles of Educated Women*, 1966, pp. 4-5. It should be noted that while Ginzberg *et al.*, focused on the lives of highly educated women, I feel that the career contrasts between men and women are applicable to other educational levels.

[7] H.S. Becker, *Sociological Work*, 1970, pp. 261-267.

[8] Lucy M. Cohen, "The Female Factor in Resettlement, 1977, pp. 27-30.

[9] Cynthia Nelson, "Reconceptualizing Health Care," in Virginia Olesen, *Women and Their Health: Research Implications for a New Era*, 1975, pp. 58-62.

[10] *Ibid.*, pp. 61-62.

APPENDIX A

LETTER OF INTRODUCTION TO PARENTS
(SPANISH VERSION)

Estimados Padres de Familia:

Tengo el gusto de comunicarles que la Universidad Católica ha solicitado nuestra colaboración para realizar un estudio cuyos resultados se espera sirvan en el futuro para una mayor comprensión de la salud y adaptación de familias latinoamericanas en Washington.

No quisiera dejar pasar esta oportunidad sin destacar la importancia de su colaboración para llevar a feliz término este estudio. (Name of school) sin embargo, deja su participación estrictamente en base voluntaria. Toda información es estrictamente confidencial y anónima.

Los datos serán obtenidos por medio de entrevistas realizadas en el lugar que cada familia considere mas adecuado. La Dra. Lucy M. Cohen o una de sus colegas se pondrán en contacto directamente con Uds.

Atentamente,

____
(Principal or designated school official)

LETTER OF INTRODUCTION TO PARENTS
(ENGLISH VERSION)

Dear Parents:

It is my pleasure to inform you that the Catholic University of America has requested our participation in a study which we hope can contribute to a better understanding of the health and health-related problems of families in Latin American origin who have children in elementary schools in Washington, D.C.

The collaboration of parents or families of our students is important for the success of the study. Your participation, however, is voluntary. As is expected, the names of families or of their place of residence would not appear in any report in order to protect the confidentiality of the information and of the analysis.

Data will be collected by means of interviews at a location each family considers most convenient. You will be contacted directly by Dr. Lucy M. Cohen or one of her co-workers.

Sincerely yours,

Principal

APPENDIX B

THE RESEARCH PROCESS: PERMISSIONS AND INITIAL RAPPORT

Written permission to conduct research was first secured from the appropriate administrative and school level authorities in the two school systems. In addition, the administrative officers of the school health division of the city, and chiefs of selected health centers and their staffs were informed of the research plans. They contributed their ideas and also offered fruitful perspectives about the provision of health services.

There were many details involved in what anthropologists and the proverbial 'man on the street' have aptly described as 'time consuming' efforts in the establishment of effective research relations with agencies in a complex urban environment such as Washington. For example, prior to securing official approval in one of the two school systems, I contacted and interpreted my work to four officials at various levels in the system, and to five types of administrative officers in the health care system. I considered the interpretation of the nature of this research project and the necessary expressions of approval but one aspect of the process of research. I purposefully cultivated an atmosphere in which we could address ourselves to the concerns about ethnic populations and the delivery of health services which were of joint interest to researchers, to practice-oriented administrators and to staff. I hoped that this nurturing of mutual investment in research and practice-related concerns early in the research would lead to ongoing opportunities for "feedback" which would, in the long run, serve the interest of the respondents and other residents of the city.

At the time of initial contact with school respondents, the interviewer carried letters of introduction from the schools, and copies of the letters which the principals or their designated authority had sent to parents. These letters, written in Spanish and with an English translation, explained the general purpose of the investigation and assured each respondent that they were free to accept or refuse the invitation to contribute to the research. Many persons had not received the school letters due to problems with mail delivery in apartment buildings. Even with the letters in hand, however, some parents were not clear on the nature of the research study and viewed the letter like other forms sent to them which they do not fully understand. The limited literacy level of some respondents, or the more commonly found lack of clarity about the details of the functioning and activities of the schools led to this typical reaction.

The first part of the initial research contact was spent in explanations about the study, and in responses to questions about personal identities and professional backgrounds of the researchers. Undoubtedly, without the introduction of school authorities, parental collaboration could not have been effectively elicited.

APPENDIX C

OPINIONES SOBRE SALUD
(SPANISH VERSION)

1. ¿Al presente tiene Ud. algun problema de salud?
____sí ____no

2. ¿Sufre de temblores de las manos tanto que le hacen sentir incómodo(a)?
3. Con frecuencia____ 2. De vez en cuando____ 1. Nunca____

3. ¿Le sudan frío las manos o los pies?
3. Con frecuencia____ 2. De vez en cuando____ 1. Nunca____

4. ¿Se siente molesta(o) por palpitaciones fuertes del corazón?
3. Con frecuencia____ 2. De vez en cuando____ 1. Nunca____

5. ¿Tiene tendencia a sentirse cansado(a) en la mañana?
3. Con frecuencia____ 2. De vez en cuando____ 1. Nunca____

6. ¿Tiene dificultad en dormir o en continuar el sueño?
3. Con frecuencia____ 2. De vez en cuando____ 1. Nunca____

7. ¿Que tan a menudo siente indigestión (Malestares de estómago?
3. Con frecuencia____ 2. De vez en cuando____ 1. Nunca____

8. ¿Le molestan las pesadillas (sueños que le dan miedo o ponen inquieto(a)?
3. Con frecuencia____ 2. De vez en cuando____ 1. Nunca____

9. ¿Le molestan *sudores fríos?* (por todo el cuerpo)
3. Con frecuencia____ 2. De vez en cuando____ 1. Nunca____

10. ¿Sufre Ud. de diferentes clases de malestares (enfermedades) en distintas partes del cuerpo?
3. Con frecuencia____ 2. De vez en cuando____ 1. Nunca____

11. ¿Ud. fuma?
3. Con frecuencia____ 2. De vez en cuando____ 1. Nunca____

12. ¿Tiene falta de apetito?
3. Con frecuencia____ 2. De vez en cuando____ 1. Nunca____

13. ¿La falta de salud afecta la cantidad de trabajo (oficios de la casa) que Ud. acostumbra hacer?
3. Con frecuencia____ 2. De vez en cuando____ 1. Nunca____

14. ¿Siente debilidad general o falta de energías?
3. Con frecuencia____ 2. De vez en cuando____ 1. Nunca____

15. ¿Sufre de mareos? (Las cosas se mueven alrededor suyo?)
3. Con frecuencia____ 2. De vez en cuando____ 1. Nunca____

16. ¿Baja fácilmente de peso en épocas de preocupación?
3. Con frecuencia____ 2. De vez en cuando____ 1. Nunca____

17. ¿Siente dificultad para respirar cuando no está haciendo ejercicio fuerte?
3. Con frecuencia____ 2. De vez en cuando____ 1. Nunca____

18. ¿Se siente con suficiente salud para llevar a cabo las cosas que le gustaría hacer?
1. Con frecuencia____ 2. De vez en cuando____ 3. Nunca____

19. ¿Se siente en buen estado de ánimo?
1. Con frecuencia____ 2. De vez en cuando____ 3. Nunca____

20. ¿Duda si todavía queda algo que valga la pena?
3. Con frecuencia____ 2. De vez en cuando____ 1. Nunca____

APPENDIX C

THE PRESENT TENSE HEALTH OPINION SURVEY
(ENGLISH VERSION)

1. Do you have any physical or health problems at the present?
   3. Yes____ 1. No____

2. Do your hands tremble enough to bother you?
   3. Often____ 2. Sometimes____ 1. Never____

3. Are you troubled by your hands or feet sweating so that they feel damp and clammy?
   3. Often____ 2. Sometimes 1. Never____

4. Are you bothered by your heart beating hard?
   3. Often 2. Sometimes 1. Never____

5. Do you tend to feel tired in the morning?
   3. Often 2. Sometimes 1. Never____

6. Do you have any trouble getting to sleep or staying asleep?
   3. Often____ 2. Sometimes____ 1. Never____

7. How often are you bothered by having an upset stomach?
   3. Often____ 2. Sometimes____ 1. Never____

8. Are you bothered by nightmares (dreams that frighten or upset you)?
   3. Often____ 2. Sometimes____ 1. Never____

9. Are you troubled by "cold sweats"?
   3. Often 2. Sometimes 1. Never____

10. Do you feel that you are bothered by all sorts (different kinds) of ailments in different parts of you body?
    3. Often____ 2. Sometimes____ 1. Never____

11. Do you smoke?
    3. Often____ 2. Sometimes____ 1. Never____

12. Do you have loss of appetite?
    3. Often____ 2. Sometimes____ 1. Never____

13. Does ill health affect the amount of work (or housework) that you do?
    3. Often____ 2. Sometimes____ 1. Never____

14. Do you feel weak all over?
3. Often____ 2. Sometimes____ 1. Never____

15. Do you have spells of dizziness?
3. Often____ 2. Sometimes____ 1. Never____

16. Do you tend to lose weight when you worry?
3. Often____ 2. Sometimes____ 1. Never____

17. Are you bothered by shortness of breath when you are not exerting yourself?
3. Often____ 2. Sometimes____ 1. Never____

18. Do you feel healthy enough to carry out the things that you would like to do?
1. Often____ 2. Sometimes____ 3. Never____

19. Do you feel in good spirits?
1. Often____ 2. Sometimes____ 3. Never____

20. Do you sometimes wonder if anything is worthwhile anymore?
3. Often 2. Sometimes____ 1. Never

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